

**AN INTERMEDIARY'S GUIDE
TO
WISCONSIN INSURANCE LAW**



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INTRODUCTION

This manual is written both for those who are preparing for insurance exams and for those who want to keep up-to-date on Wisconsin insurance law. It is a brief summary of the laws and rules, and is not complete. It is suggested that agents obtain a complete copy of the laws and rules.

Copies of the Wisconsin Administrative Code and the Statutes can be obtained from the Department of Administration, Document Sales and Distribution, 202 South Thornton Avenue, Madison, WI 53702, telephone (608) 266-3358. The Wisconsin Insurance Laws are also available from NILS Publishing Company, 20675 Bahama Street, P. O. Box 2507, Chatsworth, CA 91311, or Document Sales and Distribution.

An applicant for an agent license has to pass a written examination. Each person taking an examination will be responsible for the general material covered in Chapters I, II, III, IV, and VIII as well as the material in other chapters which specifically applies to the line or lines of insurance for which the person wants to be licensed.

The material is presented in a question and answer format. It should be read carefully and completely. An effort has been made to simplify complex statutory language.

If an answer or example seems confusing, misleading, or incorrect, consult the applicable statute or insurance rule. Included in most answers are numbers in brackets "[]" which refer the reader to specific state statutes and/or insurance rules of the Wisconsin Administrative Code from which the answer was drawn.

Some of the examples in the general material of Chapters I, III, and IV use fact situations which pertain to a particular line of insurance. These examples illustrate certain points only and do not mean that a person applying for one type of license would be expected to be knowledgeable in another insurance line.

A statute is a state law which was passed by the Wisconsin Legislature. In the manual, statutory references have an "s." or a "ch." before them, as in "s. 628.34" or "ch. 628." This refers the reader to a particular section or chapter of the Wisconsin Statutes (Wis. Stat.). An insurance rule implements the general requirements of the law. In this manual, an insurance rule has an "s. Ins" before it, as in "s. Ins 3.27," which refers the reader to s. Ins 3.27 of the Wisconsin Administrative Code (Wis. Adm. Code). An insurance rule is promulgated by the Commissioner under authority delegated to the Commissioner by the Wisconsin Legislature.

The office will update the manual periodically but readers should not rely solely on the material in this manual to keep informed of statute and rule changes. This guide is not intended to be a complete summary of the statutes and rules about which agents should be aware. Particular attention should be given to *The Wisconsin Insurance News*, the quarterly newsletter available on OCI's Web site (oci.wi.gov) which is prepared by the Commissioner's office.

CHAPTER I

POWERS AND DUTIES OF THE COMMISSIONER

Wisconsin statutory law vests the Commissioner with broad powers and duties to protect the public and to ensure that the insurance industry meets the insurance needs of Wisconsin citizens responsibly and adequately. These powers and duties are exercised in accordance with procedures designed to assure due process and judicial safeguards.

The Commissioner has broad rule-making authority, limited only by the proposed rule's relevance to the related statutes and by general legal and constitutional restraints. The Commissioner supplements statutory law by interpreting that law through the formal processes of rule-making and adjudication, and by informal executive decisions.

Rule-making builds up a body of insurance regulation which is a guide to regulated interests and the general public. The rule-making procedure includes the publishing of proposed rules and an invitation for comment at a scheduled hearing. This procedure permits people to express their opinions about the proposed rule's impact on their businesses, activities, and interests, and helps the Commissioner formulate rules based on sound public policy considerations.

The Commissioner has wide power to issue orders to enforce the statutes and rules. The existence of such enforcement powers enables the Commissioner to negotiate settlements and induce compliance in most instances without the necessity of taking formal disciplinary action. However, the Commissioner will use enforcement powers if the particular situation demands it.

The Commissioner has full administrative power of investigation, usually exercised through investigatory, educational, or multi-purpose hearings.

GENERAL POWERS

WHAT ARE THE COMMISSIONER'S GENERAL DUTIES AND POWERS?

The Commissioner is responsible for administering and enforcing the insurance laws of Wisconsin. The Commissioner must act as promptly as possible on all matters placed before the office.

The Commissioner and the office possess all the powers specifically granted or reasonably implied by the statutes. This enables the office to perform the duties necessary to enforce the law, including adoption of rules.

[s. 601.41]

MAY THE COMMISSIONER ISSUE ORDERS?

The Commissioner is empowered to issue all prohibitory, mandatory, and other orders as are necessary to secure compliance with the law.

At the request of any person who would be affected by an order, the Commissioner may issue a declaratory order to clarify the person's rights and duties under Wisconsin law.

No rule or order may be issued as a result of a hearing unless the statutory requirements for administrative procedures are met.

[s. 601.41(4)]

MAY THE COMMISSIONER REQUIRE PERSONS TO SUBMIT REPORTS AND OTHER MATERIAL?

(Persons as used in this context includes individuals, insurers, agencies, and other corporate entities.)

The Commissioner has the authority to require from any person subject to regulation under Wisconsin insurance law:

- Statements, reports, answers to questionnaires, and other information in whatever reasonable form the Commissioner designates and at such reasonable intervals as the Commissioner may choose; and
- Full explanation of the programming of any data processing system, computer, or any other information storage system or communication system in use.

The Commissioner may prescribe forms for the reports and specify who must execute or certify them. The Commissioner may require verification of any report.

The Commissioner may prescribe reasonable data handling standards and techniques to ensure that timely, reliable information will be available.

[s. 601.42]

WHAT PERSONS ARE REQUIRED TO REPLY TO THE COMMISSIONER'S REQUESTS FOR INFORMATION?

The following persons are required to reply promptly in writing or in any other designated form, to any written inquiry from the Commissioner requesting a reply:

- Any officer, manager, or general agent of any insurer, authorized to do or doing an insurance business in Wisconsin;
- Any person controlling or having a contract under which he or she has a right to control such an insurer, whether exclusively or otherwise;
- Any person with executive authority over the affairs of an insurer; and
- Any insurance intermediary or other person licensed under the insurance laws.

Failure to reply may result in penalties.

[s. 601.42(4)]

EXAMINATION POWERS AND DUTIES

WHAT POWER OF EXAMINATION DOES THE COMMISSIONER HAVE?

The Commissioner has the power to examine the affairs and condition of the persons listed below whenever the Commissioner deems it necessary to be informed about any matter related to the enforcement of the insurance laws. These persons include:

- Any licensee under insurance laws (including insurers, intermediaries, corporations, etc.);
- Any applicant for a license;
- Any person or organization transacting, or in the process of organizing to transact, the insurance business in this state;
- Any advisory organization serving any of the above in Wisconsin; and
- Any prelicensing school, continuing education provider, course, or instructor.

The Commissioner may determine the scope of each examination and must take into account all relevant factors, including but not limited to:

- Length of time the examinee has been doing business;
- Length of time the examinee has been licensed in Wisconsin;
- Nature of the business being examined; and
- Nature of the accounting records available and the nature of the examinations performed elsewhere.

The examination of an insurer domiciled in another country is limited to insurance transactions and assets in the United States, unless the Commissioner orders otherwise after finding that extraordinary circumstances necessitate a broader examination.

[s. 601.43, ss. Ins 26.10, 28.10]

DOES THE COMMISSIONER HAVE ANY DUTY TO EXAMINE?

The Commissioner is required to examine every domestic insurer (an insurer created and organized under Wisconsin law) and every licensed rate service organization.

[s. 601.43(2)(a)]

WHAT INFORMATION MUST THE EXAMINEE MAKE AVAILABLE TO THE COMMISSIONER?

On demand, every examinee must make available to the Commissioner any of its own accounts, records, documents, or evidences of transactions as well as the accounts, records, documents, and evidence of transactions of any persons who may be examined collaterally.

Failure to comply is deemed to constitute concealment of records, a possible ground for liquidation of the business of the examinee. However, if the examinee is unable to obtain the accounts, records, documents, or evidences of transactions from other persons, failure will not be deemed concealment if the examinee immediately terminates its relationship with such persons.

[s. 601.43(1)(c)]

WHO PAYS THE COST OF EXAMINATIONS CONDUCTED BY THE COMMISSIONER?

For domestic insurers, the costs of examination are apportioned among all domestic insurers based on a formula related to premiums written in the state.

For nondomestic and town mutual insurers, reasonable costs of the examination are paid by the examinee unless the Commissioner finds that payment would place an unreasonable burden on the examinee.

Prelicensing schools and continuing education providers may be billed for reasonable costs of an examination.

The costs include the salaries and expenses of the examiners and any other expenses which may be directly apportioned to the examination. Payment is due 10 days after the examinee has been served a detailed account of the costs.

[s. 601.45, ss. Ins 16.01, 26.10(3), 28.10(3)]

WHAT ABOUT COLLATERAL EXAMINATIONS?

As far as reasonably necessary for an examination, the Commissioner may examine the accounts, records, documents, or evidences of transactions of:

- Any officer, manager, general agent, employee, or person who is in charge of any segment of the examinee's affairs;
- Any person controlling or having the right to control the examinee, whether exclusively or with others;
- Any person under the control of the examinee; or
- Any person under the control of a person who controls or has a right to control the examinee whether exclusively or with others.

[s. 601.43(1)(b)]

DOES THE COMMISSIONER HAVE ACCESS TO ANY OTHER RECORDS DURING THE EXAMINATION PROCESS?

The Commissioner's office has access to the records of any agency of the state government or of any political subdivision.

[s. 601.49]

ENFORCEMENT PROCEDURES

WHEN ARE HEARINGS REQUIRED?

The Commissioner must hold a hearing before issuing an order or rule whenever the insurance laws or the administrative procedure requirements expressly provide for a hearing. Unless the insurance laws prescribe special procedures, all hearings must comply with the procedures set out in ch. 227, Wis. Stat., and ch. Ins 5, Wis. Adm. Code. The statutes do provide for the summary suspension of an intermediary's license if the Commissioner finds that public health, safety, and welfare requires emergency action.

If the intermediary fails to pay a fee when due, the Commissioner may suspend or revoke the license without a hearing. If the Commissioner and the intermediary agree, an intermediary may consent to a revocation without a hearing. The Commissioner may suspend the license of a person who fails to comply with continuing education standards. Otherwise, the Commissioner may revoke, suspend, or limit a permanent license of an intermediary only after a hearing and an opportunity for judicial review.

The Commissioner must hold a public hearing before adopting any rule unless the rule is procedural rather than substantive, is an emergency rule, or is an exception listed under s. 227.02 of the Administrative Procedure Act.

The Commissioner may hold informal hearings and public meetings for the purposes of investigation, for ascertaining public sentiment, or to inform the public.

[ss. 601.41, 601.62, 628.10, 628.10(2)(b), ch. 227]

DOES AN APPLICANT FOR AN INTERMEDIARY LICENSE HAVE A RIGHT TO A HEARING AFTER THE COMMISSIONER'S DECISION NOT TO ISSUE A LICENSE TO THE APPLICANT?

Before being granted an original license in a particular line of insurance, the applicant must show the Commissioner that he or she is competent and trustworthy. Applicants have the right to a hearing to appeal the Commissioner's decision not to issue a license. Such hearing and appeal must comply with the procedures set forth in ch. 227, Wis. Stat.

When an order is issued without a hearing, any aggrieved person may demand a hearing within 30 days after the mailing of the order. Failure to demand a hearing within 30 days constitutes a waiver of the right to a hearing. The demand for a hearing must be made in writing and served on the Commissioner directly or left at the Commissioner's office. The Commissioner must hold the requested hearing not less than 10 days nor more than 60 days after delivery of the request for a hearing.

[s. 601.62, s. Ins 6.59]

MAY A PERSON REQUEST A REHEARING OF A PREVIOUS HEARING'S DECISION?

After a final order is entered, any aggrieved person may request a rehearing within 20 days. The filing of a petition for re-hearing does not suspend or delay the effective date of the order unless the petition is granted or the order is superseded, modified, or set aside as provided by law.

The Commissioner may grant a re-hearing only if there was a material error of law or fact, or if new evidence is discovered which merits reversing or modifying the order. If the Commissioner has not acted on the petition within 20 days after its filing, the petition is considered to have been denied.

[s. 227.12]

IS A PERSON REQUIRED TO TESTIFY AND GIVE EVIDENCE AT A HEARING?

No person is excused from attending, testifying, or giving evidence on the grounds that the testimony or evidence required from the person may tend to incriminate the person or subject the person to a penalty or forfeiture. After claiming the privilege against self-incrimination, a person may not be criminally prosecuted for any act upon which the person is compelled to testify or produce evidence. A person is not exempt, however, from prosecution and punishment for perjury, false swearing, or contempt committed in testifying.

[s. 601.62(5)]

WHAT ENFORCEMENT SANCTIONS ARE AVAILABLE TO THE COMMISSIONER?

Whenever a person fails to comply with an order, the Commissioner may start a legal action directing the person to comply with the Commissioner's order and restraining that person from further noncompliance. In addition, forfeitures, civil penalties, and criminal sanctions may be levied by the Commissioner.

[s. 601.64]

WHAT IS A COMPULSIVE FORFEITURE?

After a person has failed to comply with an order, the Commissioner may give notice of intent to proceed with a compulsive forfeiture. If the person fails to comply with the order within two weeks after the notice is given, the Commissioner may start a legal action for a compulsive forfeiture in the amount a court would consider just. Such a forfeiture cannot exceed \$5,000 for each day that the violation continues between the commencement of the action and the time the court renders its judgment.

No compulsive forfeiture will be imposed if the person had complied with the order by the time the action was started. If any violation of an order occurred while any proceeding for judicial review of the order was pending, a compulsive forfeiture will not be imposed unless the court certifies that the claim of invalidity or nonapplicability of the order was frivolous or a sham. If the person refuses to obey the order after a judgment is rendered, the Commissioner may begin a new action for a compulsive forfeiture and may continue commencing such actions until the person complies with the order.

[s. 601.64(2)]

WHAT ABOUT FORFEITURES AND CIVIL PENALTIES?

Any person who violates an effective order or any insurance statute or rule may be required to forfeit to the state, in addition to any other forfeiture imposed, twice the amount of any profit gained from the violation.

Any person who violates an order after proper notice may be required to forfeit to the state not more than \$1,000 for each violation. Each day the violation continues constitutes a separate offense.

Any person who violates an insurance statute or rule may be required to forfeit to the state not more than \$1,000 for each violation. If the statute or rule imposes a duty to make a periodic or recurring report to the Commissioner, each week of delay in complying with the duty constitutes a new violation.

[s. 601.64(3)]

Forfeiture of up to \$1,000 may be levied against "firms" for violations by an insurance agent of a provision of an insurance statute or rule if the violation is in connection with an insurance policy or group certificate obtained or to be obtained through the firm if:

- The firm regularly utilizes the insurance agent to market insurance policies or group certificates;
- The primary insurance marketing activities of the insurance agent are in connection with insurance policies or group certificates obtained or to be obtained through or from the firm; or
- The insurance agent is employed by or is under contract with the firm to market insurance policies or group certificates.

A "firm" means a person that markets insurance but does not include an insurer.

[s. 601.65]

A person who is ordered to pay a forfeiture may demand a hearing. If the person fails to request a hearing, the order is conclusive as to the person's liability. The scope of review for forfeitures is as specified under s. 227.57, Wis. Stat.

[s. 601.64(3)(d)]

WHAT ABOUT CRIMINAL PENALTIES?

A person who:

- Intentionally violates;
- Intentionally permits any person over whom he or she has authority to violate; or
- Intentionally aids any person in violating;

any insurance statute or rule of this state or any effective order issued by the Commissioner may be fined not more than \$5,000 or imprisoned for a period not to exceed three years or both. A corporation may be fined not more than \$10,000. These penalties apply unless a specific penalty is provided elsewhere in the statutes. "Intentionally" means that the person acting intends to do something or cause a specific result or believes an act will cause a specific result.

[s. 601.64(4)]

WHAT IS THE INSURANCE SECURITY FUND?

The Insurance Security Fund was established to provide certain protections to insureds in the event of an insurer's liquidation. Money in the fund comes from assessments against all insurers, with limited exceptions, licensed to transact business in the state. The fund is administered by a board of directors to include the attorney general, the state treasurer and the commissioner of insurance.

The primary duty of the board is to oversee the adjudication process of unpaid claims to cases where a court has issued an order of liquidation against an insurer authorized to do business in the state.

[ch. 646]

CHAPTER II

INSURANCE MARKETING

Chapter 628, Wis. Stat., on insurance law has three main parts: the licensing of insurance intermediaries, regulation of insurance marketing practices, and compensation of insurance intermediaries. Under the statutes, the term “intermediary” is used to include all the varieties of agency representation of either policyholders or insurance companies in the marketing of insurance. The different classes of “intermediaries” are: intermediary, intermediary-partnerships and corporations, intermediary-surplus lines agents and brokers, managing general agents, reinsurance intermediary brokers and managers, and viatical settlement brokers.

Wisconsin law places some restrictions on combining different intermediary roles in the same transaction.

The licensing of intermediaries is concerned solely with the qualifications of the person applying for the insurance license. The essential requirement is that the insurance intermediary be trustworthy and competent. The competence includes a basic understanding of fundamental insurance law as well as particular knowledge concerning specific statutes and rules.

Wisconsin insurance statutes outline and define the general requirements which the insurance intermediary must follow. In addition, the insurance intermediary must understand and follow the administrative code which has been adopted by the Commissioner. These rules clarify and expand on the general statutory language by spelling out specific practices which may or may not be done by the insurance intermediary or the insurance company. The standards of professional conduct set out in the statutes and rules will be strictly enforced by the Commissioner.

WHAT IS AN INTERMEDIARY?

A person is an “intermediary” if the person does or assists another in any of the following:

- Soliciting, negotiating, or placing insurance or annuities on behalf of an insurer or a person seeking insurance or annuities; or
- Advising other persons about insurance needs and coverages.

The following persons, however, are not considered “intermediaries” under Wisconsin law:

- A regular salaried officer, employee, or other representative of an insurer or licensed intermediary, who devotes substantially full-time to activities other than those listed immediately above and does not receive any compensation that is directly dependent upon the amount of insurance business obtained;
- A regular salaried officer or employee or a person seeking to procure insurance, who receives no compensation that is directly dependent upon the amount of insurance coverage procured;

- A person who gives incidental advice in the normal course of a business or professional activity other than insurance consulting. Neither the person nor the person's employer may receive compensation directly or indirectly on account of any insurance transaction that results from such advice;
- A person who, without special compensation, performs incidental services for another at another's request without providing advice or technical or professional services of the kind normally provided by an intermediary;
- A holder of a group insurance policy, or any other person involved in mass marketing, with respect to the person's administrative activities in connection with the policy. Such a person may not receive any compensation for the administrative work beyond actual expenses which can be estimated on a reasonable basis;
- A person who provides information, advice, or service for the principal purpose of reducing loss or risk;
- A person who gives advice or assistance without compensation; or
- A representative of a common carrier who sells only over-the-counter, short-term travel accident ticket policies and baggage insurance.

[s. 628.02(1)]

WHAT ARE THE TYPES OF INTERMEDIARIES?

INTERMEDIARY-INSURANCE AGENT

An intermediary is an insurance agent if the intermediary acts as an intermediary other than as a broker.

[s. 628.02(4)]

INTERMEDIARY-BROKER

An intermediary is an insurance broker if the intermediary acts in the procuring of insurance on behalf of an applicant for insurance or an insured. An insurance broker does not act on behalf of the insurer except by collecting premiums or performing other ministerial acts.

[s. 628.02(3)]

INTERMEDIARY-SURPLUS LINES AGENT OR BROKER

A surplus lines agent or broker is one separately licensed to place insurance with unauthorized (nonlicensed) insurers.

[ss. 628.02(5), 618.41]

INTERMEDIARY-CORPORATIONS AND PARTNERSHIPS

Partnerships and corporations in the insurance business in Wisconsin may be licensed.
[s. 628.04, s. Ins 6.58]

REINSURANCE INTERMEDIARY-BROKER

A reinsurance intermediary-broker places ceded reinsurance in this state and has an office, or does business in this state and has an office outside this state unless it is licensed under a similar law in another state.

[s. Ins 47]

REINSURANCE INTERMEDIARY-MANAGER

A reinsurance intermediary-manager has significant authority regarding assumed reinsurance of an insurer and acts as its agent.

[s. Ins 47]

MANAGING GENERAL AGENT

Wisconsin law defines a managing general agent as a person who manages all or part of the insurance business of an insurer or manages a separate division, department, or underwriting office; acts as an agent for the insurer; AND with or without the authority, either separately or together with affiliates, directly, or indirectly: a) produces and underwrites in any one quarter or year an amount of gross direct written premium equal to or more than 5% of the policyholder surplus as reported in the last annual statement of the insurer; and b) adjusts or pays claims in any one quarter or year in excess of 3% of the policyholder surplus as reported in the last annual statement of the insurer, or negotiates reinsurance on behalf of the insurer, or both.

[s. Ins 42.01, s. 628.49]

WHAT ARE THE REQUIRED CONTRACT PROVISIONS BETWEEN MANAGING GENERAL AGENTS AND INSURERS?

No person may act as a managing general agent for an insurer unless the person first enters into and subsequently complies with a written contract between the parties which sets forth the responsibilities of each party and, where both parties share responsibility for a particular function, specifies the division of the responsibilities, and which contains the following minimum provisions:

- 1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination.
- 2) The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

- 3) All funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in a financial institution which is a member of the federal reserve system. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than 3 months estimated claims payments and allocated loss adjustment expenses.
- 4) The managing general agent will maintain separate records of business written by the managing general agent for the insurer. The insurer shall have access to, and the right to copy, all accounts and records related to its business in a form usable by the insurer and the Commissioner shall have access to all books, bank accounts and records of the managing general in a form usable by the Commissioner.
- 5) The managing general agent may not assign the contract in whole or in part.
- 6) Appropriate underwriting guidelines include, but are not limited to: a) the maximum annual premium volume; b) the basis of the rates to be charged; c) the types of risks which may be written; d) maximum limits of liability; e) applicable exclusions; f) territorial limitations; g) policy cancellation provisions, and h) the maximum policy period.
- 7) The insurer may cancel or nonrenew any policy of insurance subject to the applicable laws and rules.
- 8) If the contract permits the managing general agent to settle claims on behalf of the insurer: a) the managing general agent shall report all claims to the insurer in a timely manner; and b) shall send a copy of the claim file to the insurer at its request or as soon as it becomes known that the claim has equalled or exceeded or has the potential to equal or exceed an amount which is .5% of the insurer's policyholder surplus as of December 31 of the immediately preceding calendar year or exceeds the limit set by the insurer, whichever is less; involves a coverage dispute; may exceed the managing general agent claims settlement authority; is open for more than 6 months; or is closed by payment of an amount equal to or greater than .5% of the insurer's policyholder surplus as of December 31 of the immediately preceding calendar year or an amount set by the insurer, whichever is less.
- 9) All claim files will be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer the files shall become the sole property of the insurer or its estate. The contract may provide that the managing general agent may have reasonable access to and the right to copy the files on a timely basis.
- 10) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.
- 11) The managing general agent will timely transmit to the insurer appropriate data from electronic claims files.

- 12) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the managing general agent until one year after they are earned for property insurance business and 5 years after they are earned on casualty business and not until the profits have been verified as required by law.
- 13) The managing general may not: a) bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules; b) commit the insurer to participate in insurance or reinsurance syndicates; c) appoint any subproducer without assuring that the subproducer is lawfully licensed to transact the type of insurance for which the subproducer is appointed; d) without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed 1% of the insurer's policyholder surplus as of December 31 of the last completed calendar year; e) collect any payment from a reinsurer, or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer; f) permit its subproducer to serve on the insurer's board of directors; g) jointly employ an individual who is employed by the insurer; or h) appoint a submanaging general agent.

[s. Ins 42.03, s. 628.49]

WHAT IS A VIATICAL SETTLEMENT BROKER?

A viatical settlement broker is a person who, for a fee, commission, or other valuable consideration, offers or attempts to negotiate settlements between a life insurance policyholder and one or more viatical settlement providers. Viatical settlement brokers must apply for a license annually and must maintain professional liability insurance.

[s. 632.68(1), (3)]

ARE THERE LICENSING REQUIREMENTS FOR VIATICAL SETTLEMENT PROVIDERS?

Yes. With few specified exceptions, viatical settlement providers must apply for and obtain a license before soliciting or paying viatical settlements or entering into contracts with life insurance policyholders.

[s. 632.68(2)]

WHEN IS AN INTERMEDIARY REQUIRED TO GET A LICENSE?

A person may not perform, offer to perform, or advertise any service as an intermediary in Wisconsin unless the person obtains a license. No person may use the services of another as an intermediary if the person knows or should know that the other does not have a license as required by law.

The Commissioner may by rule exempt certain classes of persons from the requirements of obtaining a license. Persons may be made exempt if the functions they perform do not require special competence or trustworthiness or the regulatory surveillance made possible by licensing, or if other existing safeguards make regulation unnecessary.

An insurance contract is valid even if sold or serviced by an unlicensed intermediary.

[s. 628.03]

EXAMPLES

Do the following persons need to be licensed under Wisconsin law:

- An employee or a collection agency that collects insurance premiums from delinquent policyholders?

No. This is a purely administrative function which does not require the special qualifications of an insurance intermediary and does not come under s. 628.02, Wis. Stat.

- A person who incidentally advises other persons about insurance needs and coverages during the normal course of his or her noninsurance-related business, and who receives no direct or indirect compensation on account of any transaction which results from the advice?

No. This person comes under the exceptions in s. 628.02, Wis. Stat., and is not an intermediary.

- A person who places insurance for an insurance company on a door-to-door basis?

Yes. Under s. 628.02, Wis. Stat., this person is an insurance marketing intermediary and is required to obtain a license.

- A person who advises other persons about insurance needs and coverages and is directly compensated by an insurance company or the insured?

Yes. Under s. 628.02, Wis. Stat., the person is an insurance marketing intermediary and is required to obtain a license.

WHAT REQUIREMENTS MUST A PERSON MEET IN ORDER TO BE ISSUED A LICENSE?

A person must qualify on his or her own merits. The Commissioner must issue a license to act as an intermediary to any person, corporation, or partnership who pays the applicable fee and satisfies the Commissioner that such person or entity meets the statutory requirements.

The applicant must have the honest intention to do business as an intermediary. A corporation or partnership must have this intention spelled out in its articles of incorporation or association.

The applicant must be competent and trustworthy. If the applicant is a corporation or partnership, its principal partners, officers, or directors must be competent and trustworthy.

A competent and trustworthy intermediary must be well-informed on the kinds of insurance the intermediary is qualified to write. The intermediary must be able to analyze the insurance needs of clients and be able to recommend the type of insurance best suited to their respective needs. The intermediary may make no false statements nor any misrepresentations by omission of facts, inference, or subterfuge in any relations with clients, insurance companies, or other intermediaries. The intermediary must take all reasonable steps so clients are informed as to the extent and limitations of coverage provided by their contracts. Intermediaries must manage agency financial affairs in accordance with the high standards applicable to a fiduciary. They must conform to all applicable insurance statutes and rules.

[ss. 628.04, 628.34, s. Ins 6.59]

The person who is applying for a license must also comply with the special statutory requirements regarding issuance of insurance for the intermediary's own personal needs.

[s. 628.51]

Residence in Wisconsin is not a requirement for licensing. If the applicant is not a resident of Wisconsin, the applicant must agree to be subject to the powers of the Commissioner and the state courts on any matter related to the applicant's intermediary activities in the state.

Wisconsin law does not require sponsorship by an insurance company for a person to qualify as an intermediary.

[s. 628.04]

WHAT ADDITIONAL REQUIREMENTS ARE THERE FOR SURPLUS LINES AGENTS OR BROKERS?

The Commissioner may issue a license to an agent or broker authorized to place surplus lines insurance if the applicant shows to the satisfaction of the Commissioner that he or she has the competence necessary to deal with the problems of surplus lines insurance. The Commissioner may by rule require an agent or broker authorized to place surplus lines insurance to supply a bond not larger than \$100,000, conditioned upon the proper performance of the person's obligations as a surplus lines agent or broker.

[s. 628.04(2)]

WHAT ARE THE REQUIREMENTS FOR INTERMEDIARY LICENSING EXAMINATIONS?

The Commissioner has the power to define classifications of intermediaries and can require different standards of competence, different examinations and different educational requirements for each class. When possible, a single license is issued to each qualified intermediary for a single fee.

Currently, only individual intermediaries, as opposed to corporations and partnerships, need to take exams for licensing. Applicants must pass a written examination for each kind of authority desired. Each examination tests the applicant's basic knowledge and understanding of the applicable laws and regulations.

Prelicensing education is required of all candidates who apply for an original resident license, and for those requesting additional major lines. Those candidates applying for an exam in the limited line of title, credit, legal expense, or managing general agents, and those who have completed a two-year Wisconsin vocational school degree in insurance, or a four-year college degree in business with an insurance emphasis are exempt from the prelicensing education requirement.

[ss. Ins 6.59 (4)(a), (c), ch. Ins 26]

An applicant who submits an application which meets the competence and trustworthiness standards outlined in the preceding sections, pays the required fee, completes the prelicensing education requirements, and obtains a passing grade on the written examination, will be issued an individual intermediary license for those lines of insurance for which the applicant is qualified. A licensed agent may act as an agent or a broker.

[s. 628.04, s. Ins 6.59]

The determination of an applicant's competence is based on the written exam given by the Commissioner and a review of the application form. A completed application consists of a completed OCI 11-041 (rev.), an original certificate of prelicensing education dated not more than one year prior to the test date, or an original exemption form and an original form DJ-LE 250 provided from the Wisconsin Department of Justice, Crime Information Bureau, dated not more than 180 days prior to the test date. Applicants who fail an exam may repeat the exam as often as necessary. Written examinations for each kind of individual licensing authority are scheduled at various test centers located around the state.

A person wishing to sell town mutual nonproperty insurance must obtain a property or casualty license.

[s. Ins 6.50]

ARE AGENTS REQUIRED TO COMPLETE CONTINUING EDUCATION?

Yes. All intermediaries holding a Wisconsin insurance license in any of the major lines of life, accident and health, property, casualty, personal lines P&C, or in the limited line of automobile must complete 24 credit hours in each biennium. A credit hour is defined as not less than 50 minutes of classroom instruction by an approved provider.

[s. Ins 28.04(1)(a)]

ARE ANY AGENTS EXEMPT FROM THE REQUIREMENTS?

Yes. Agents who hold ONLY a limited line insurance license for credit, legal expense, title, or managing general agent are exempt. Any resident agent completing the prelicensing education requirement for ORIGINAL licensure during the reporting period is exempt. This exemption does not apply if an agent is adding one or more lines to an existing license.

[s. Ins 28.04(2)(a), (b)]

DOES A NONRESIDENT AGENT HAVE TO SATISFY WISCONSIN'S CONTINUING EDUCATION REQUIREMENTS IF THE AGENT HAS SATISFIED THE REQUIREMENTS IN THE STATE WHERE THE RESIDENT LICENSE IS ISSUED?

No. Nonresident agents must comply with requirements in their home state.

[s. Ins 28.04(2)(c)]

WHAT HAPPENS IF AGENTS FAIL TO MEET CONTINUING EDUCATION REQUIREMENTS?

An agent deficient in credit hours earned will be notified by mail at least 60 days prior to the reporting date of the number of credits the agent must earn to achieve compliance. If the credit hours deficiency is not remedied by the reporting date (February 15 of each odd-numbered year), the license will be suspended. If the required hours are completed and reported during the suspension period, the license will be reinstated. If the required credit hours are not completed and reported within 60 days after notice of suspension (April 16, of each odd-numbered year), the agent's license will be revoked.

[s. Ins 28.04(1)(f), (g), (h)]

WHAT ABOUT INTERMEDIARIES WHO REPRESENT NONPROFIT SERVICE PLANS?

Intermediaries dealing with or representing nonprofit service plans (such as Blue Cross and Blue Shield plans and many health maintenance organizations) must be licensed and are subject to all the requirements of the preceding sections.

[s. 628.04]

WHAT CHANGES IN THE STATUS OF INTERMEDIARIES HAVE TO BE REPORTED?

A change in the name or home address must be reported in writing to the Commissioner within 30 days.

Every change in the membership of a partnership or in the principal officers of a corporation licensed as an intermediary must be reported to the Commissioner, as well as every significant change in the management powers of either.

Every change in status and relationships relating to the competency and trustworthiness of the intermediary must be reported to the Commissioner promptly.

All reports must comply with the reporting forms and procedures set by the Commissioner.
[s. 628.08, s. Ins 6.61]

EXAMPLES

The following changes in status are the kind which must be reported to the Commissioner within 30 days:

- Change in name or residence address;
- Change from resident to nonresident, nonresident to resident, or nonresident to nonresident status;
- Dissolution of a partnership or the taking on of new partners;
- Conviction of a crime (either misdemeanor or felony).
- Administrative action taken by any state agency which licenses individuals for any occupational activity.

ARE THERE TEMPORARY LICENSES?

The Commissioner may issue a temporary license as an intermediary for a period of not more than one year.

A temporary license may be issued only to personal representatives of a deceased or mentally or physically disabled intermediary:

- To give time for the sale of the goodwill of a business owned by the intermediary;
- For the recovery or return of the intermediary to the business; or
- To provide for the training and licensing of new personnel for the intermediary's business.

Temporary licenses may also be issued to personal representatives of an intermediary for the same purposes if the intermediary has entered active duty in the U.S. armed forces.

[s. 628.09]

WHAT IS THE LEGAL STATUS OF A TEMPORARY LICENSEE?

A temporary licensee is a fully-qualified intermediary for all purposes other than the process of licensing, the duration of the license, and the limits mentioned in the preceding section.

[s. 628.09(6)]

WHAT ARE THE LIMITATIONS ON INTERMEDIARY TEMPORARY LICENSES?

The Commissioner may, by order, limit the authority of a temporary licensee in any way he or she deems necessary to protect the insureds and the public.

The Commissioner may, by order, revoke a temporary license permit if the interests of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

[s. 628.09]

WHAT RECORDS MUST BE MAINTAINED BY AN INTERMEDIARY?

Each intermediary must maintain records for three years of cash receipts (monies received in connection with insurance), cash disbursements (monies paid out in connection with insurance), commission statements (commissions and fees allocated to the intermediary for insurance transactions), policyholder records (all records, applications, requests for changes, claims, and complaints of a policy generated by or through the intermediary), business checking accounts, and personnel records. These records must be updated at reasonable intervals or as necessary. Financial records must be kept in accordance with accepted accounting principles.

Each intermediary must maintain for a three-year period records giving the effective date of the coverage on all newly issued contracts, and records indicating that the necessary suitability inquiry and replacement procedures were followed for each individually-issued life and accident and health contract written or replaced. Intermediaries shall retain policyholder records for at least three years after termination or lapse of the policy. Special reporting requirements apply to intermediaries who are or are employed by an affiliate of a producer of title insurance.

Records must be kept at the intermediary's business address recorded with the Commissioner or at another location provided the intermediary supplies the Commissioner with written notice of the location. The intermediary must notify the Commissioner within 30 days of any change in the intermediary's business or residence address or change in the location of the records.

Each intermediary must notify the Commissioner within 30 days of any felony conviction, misdemeanor (other than those related to a motor vehicle or violation of a fish or game regulation), or any formal disciplinary action taken by any state's insurance regulatory agency or other regulatory agency which licenses the intermediary for any occupational activity.

By written agreement, an insurer may assume the responsibility to maintain these records for an intermediary if the records can be made immediately available to the Commissioner.

Each intermediary who is employed by or is an affiliate of a producer of title insurance shall maintain records for three years for each application or order for title insurance accepted in this state. The records shall state whether the application or order was directly or indirectly

referred as provided by s. Ins 3.32 (5), Wis. Adm. Code, by a producer of title insurance which is an affiliate as defined by s. Ins 3.32 (3) (a), (bm), and (c), Wis. Adm. Code, and the name of each producer of title insurance who is an affiliate and acts as broker, agent, lender, representative, or attorney in the transaction which resulted in the application or order. Each intermediary who is an affiliate of a producer of title insurance shall maintain a record of gross revenue from operations in this state from title insurance by quarter calendar year which shall separately show gross revenues from operations in this state derived from applications or orders for title insurance directly or indirectly referred by the affiliate.

[s. 601.42, s. Ins 6.61]

ARE THERE SPECIAL REQUIREMENTS FOR THE DISPOSAL OF PERSONAL MEDICAL INFORMATION?

Yes. Insurers and agents that obtain information from an insured or an individual seeking coverage, pertaining to the person's physical or mental health, medical history, or medical treatment, must take specific steps to ensure that personally identifiable information is shredded, erased, modified or otherwise handled so that no unauthorized person has access to the information.

[s. 895.505]

ARE THERE ANY SPECIAL REQUIREMENTS FOR DOOR-TO-DOOR OR PHONE SOLICITATIONS BY AGENTS?

Every insurance intermediary engaging in home solicitation selling, advertising, or offering services in home solicitation selling or providing supervision over sales practices used in home solicitation sales shall clearly and expressly disclose, at the time of initial contact or communication with a buyer, the seller's individual name, the name of the business firm or organization represented, a statement of the fact that insurance is being sold, the identity of the insurer, if the solicitation is primarily for a single insurer, and the type of insurance being solicited.

If the seller receives a check or cash, the seller shall give to the buyer a receipt or other document evidencing the transaction showing the date of the sale, a description of the type of policy applied for, the total price paid, the individual name of the person making the sale, and the name and mailing address of the insurer issuing the policy.

Persons engaging in home solicitation selling shall not:

- Represent directly or by implication that the seller is making an offer to specially selected persons unless such representations are true and the specific basis for such representations is stated at the time the representation is made.
- Represent that the seller is conducting a survey, test or research project or engaged in a contest or other venture to win a cash award, scholarship, vacation, or similar prize when the principal objective is to make an insurance sale or obtain information to help identify sales prospects.

- Use any false, deceptive or misleading representations to induce a sale, or use any plan, scheme or ruse which misrepresents that the person making the call is selling insurance, or fail to leave the premises promptly when requested to do so.

[ch. Ins 20]

MUST AN INSURANCE COMPANY LIST ITS INTERMEDIARIES WITH THE COMMISSIONER OF INSURANCE?

Except for cooperative sickness care plans formed under ch. 185, Wis. Stat., all insurance companies must report or list all appointments and all terminations of insurance intermediaries to the Office of the Commissioner of Insurance.

Before an intermediary solicits for any authorized insurer in this state, he or she must be properly listed with the insurer and the Office of the Commissioner of Insurance. Proper listing means that the insurer has submitted the appropriate forms which include the name and Wisconsin intermediary license number.

Each insurer will be billed an original listing fee for each agent originally listed during the preceding year and an annual listing renewal fee amount due for every individual intermediary serving as an agent for the insurer. Payment is required once a year in accordance with a schedule designating the calendar month of billing for each insurer.

When the appointment of an individual agent is terminated, the insurer must notify the Office of the Commissioner of Insurance, with the appropriate forms, no later than 15 days after the termination date. The insurer must also notify the intermediary in writing, no later than 7 days after filing notice with the Office of the Commissioner of Insurance, that he or she is no longer listed as a company representative, that she or he may not act as its representative, and that all materials that indicate an agency relationship with the company must be returned.

[s. 628.11, s. Ins 6.57]

WHAT REGULATION CHARGES MUST A LICENSED INTERMEDIARY PAY?

The biennial regulation amount to be paid by each licensed individual agent is \$25.00 for a resident intermediary and \$50.00 for a nonresident intermediary. Notification of the biennial regulation charge will be mailed to the home address on file with the Commissioner on or before January 15 of every even-numbered year. It must be paid within 30 days after the notice is mailed by the Commissioner. If not, the agent's license will be suspended.

[s. 601.31, s. Ins 6.63]

Agents are charged (\$10.00) for preparing and furnishing of letters of certification and (\$10.00) for preparing and furnishing letters of clearance.

Letters of certification are required by Wisconsin agents who wish to obtain a nonresident license in another state.

Letters of clearance are used by Wisconsin agents who move to another state and wish to obtain a resident agent's license in that state.

[s. 601.31]

HOW LONG DOES AN INTERMEDIARY'S LICENSE REMAIN IN EFFECT?

An intermediary's license remains in effect until it is revoked, suspended, or limited by the Commissioner; until it is voluntarily surrendered by the intermediary; until the death of the intermediary; until a court's finding that the intermediary is mentally incompetent; or until the Commissioner finds, after a hearing, that the person, corporation, or partnership is no longer qualified to act as an intermediary.

[s. 628.10(1)]

WHEN CAN AN INTERMEDIARY'S LICENSE BE REVOKED, SUSPENDED OR LIMITED?

The license of an intermediary who fails to pay a fee or fails to complete continuing education requirements when due is suspended as of the date due if the Commissioner gave the intermediary reasonable notice. If the intermediary pays or completes the requirements within 60 days after the date it is due, the license is reinstated effective on the date of suspension. If requirements are not met within 60 days, the license is revoked and the intermediary may be relicensed only after satisfying all requirements under s. 628.04, Wis. Stat., including retesting.

After a hearing, the Commissioner may revoke, suspend, or limit an intermediary's license if:

- The intermediary repeatedly or knowingly violated an insurance statute or code regulation or an enforcement order of the Commissioner;
- The intermediary's business methods and practices endanger the legitimate interests of customers and the public;
- The intermediary's financial resources are inadequate to safeguard the legitimate interests of customers and the public;
- The intermediary is unqualified as an intermediary or is not of good character.

[s. 628.10(2)]

IF A LICENSE HAS BEEN REVOKED, WHEN CAN THE INTERMEDIARY REAPPLY?

If a license is revoked for nonpayment of fees or failure to comply with continuing education requirements, the intermediary may reapply immediately.

When the Commissioner revokes an intermediary's license for any of the other reasons mentioned in the preceding section, the Commissioner may specify a time period of five years or less during which the intermediary may not apply for a new license. If the Commissioner does not specify a time period, the intermediary may not apply for five years.

[s. 628.10(3)]

ARE THERE ADDITIONAL PENALTIES FOR REVOCATION OR SUSPENSION?

Any intermediary whose license has been suspended or revoked must, when the suspension ends or when the intermediary is relicensed, pay all fees that would have been paid if the license had not been suspended or revoked, unless the Commissioner waives the payment of such fees by order.

[s. 628.10(4)]

EXAMPLES

Does the Commissioner have the power to take disciplinary action in the following cases?

- A licensed intermediary continually used unlicensed employees who were paid to advise other persons about their insurance needs?

Yes. Under s. 628.02, Wis. Stat., the employees are insurance marketing intermediaries who must be licensed. This is a repeated violation of a state statute regulating the insurance business. Under s. 628.10 (2), Wis. Stat., the Commissioner may take action against any intermediary who repeatedly or knowingly violates an insurance statute.

- A licensed intermediary failed to obey an order of the Commissioner regarding that intermediary's violation of an administrative code regulation?

Yes. Under s. 601.41 (4), Wis. Stat., the Commissioner may issue orders to secure compliance with the law. Failure of a licensed intermediary to follow the order's directives is a violation of s. 628.10 (2), Wis. Stat.

- A licensed intermediary failed to pay a required fee on time?

Yes. Failure to pay a necessary fee when required is a grounds for license suspension under s. 628.10 (2), Wis. Stat.

- When training prospective agents, a licensed intermediary corporation promoted an unfair marketing practice as a sales technique to be used by agents?

Yes. This is a violation of s. 628.10 (2), Wis. Stat. The Commissioner may take disciplinary action against a licensed intermediary whose methods or practices in the conduct of its business endanger the legitimate interests of its customers and the public.

- When selling a health insurance policy, a licensed individual intermediary failed to ask about the applicant's present insurance to determine whether or not the recommended insurance is suitable for the prospective buyer?

Yes. This is an express violation of s. Ins 3.27 (7), Wis. Adm. Code. An agent should not recommend the purchase of any individual policy to a prospective buyer without reasonable grounds to believe that the recommendation is not unsuitable for the applicant. Under s. 628.10 (2), Wis. Stat., the Commissioner has the power to revoke, suspend, or limit the intermediary's license.

WHAT ARE THE PROHIBITED PRACTICES DURING LICENSE REVOCATION OR SURRENDER?

When an intermediary is disciplined by the Office of the Commissioner of Insurance, the disciplinary period begins on the effective date of the termination of the license and ends on the date on which a new license is issued. During the disciplinary period, the Commissioner can discipline a person for using the services of a disciplined agent as well as the disciplined intermediary who provides the service.

EXAMPLES

- Who is a disciplined person?

A disciplined person includes any agent whose license was revoked or surrendered under a stipulation, any affiliate of this disciplined agent, any estate which this disciplined agent owns 10% or more of the stock, and any employee of the disciplined agent.

[s. 628.345(1)(b)]

- Can a disciplined intermediary continue to be employed by, act as an agent for, or be affiliated with a person engaged in the business of an insurance intermediary?

No. A disciplined intermediary may not serve in any of these capacities during the disciplinary period.

[s. 628.345(2)]

- Can a person pay a disciplined intermediary for services performed as an agent?

No. No person may pay consideration to, or expenses of, a disciplined intermediary that directly or indirectly relate to services performed during the disciplinary period. This does not apply to obligations incurred before the effective date of the discipline.

[s. 628.345(3)(a)]

- Can a person seek information from a disciplined intermediary during the disciplinary period?

No. No person may seek to obtain information from, or use information directly or indirectly from a disciplined intermediary during the disciplinary period for the purpose of assisting in the sale of insurance.

[s. 628.345(3)(d)]

- Can a disciplined intermediary be present during solicitation of the sale of insurance, or can a person knowingly solicit the sale of insurance with the assistance of a disciplined intermediary?

No. During the disciplinary period this is not allowed, regardless of whether the disciplined person acts as an intermediary.

[s. 628.345(3)(e)]

- Can a person use or refer to an endorsement or referral by a disciplined intermediary for the purpose of soliciting the sale of insurance?

No. During the disciplinary period of a disciplined intermediary, this practice is not allowed.

[s. 628.345(3)(f)]

WHAT MARKETING PRACTICES ARE UNFAIR?

Unfair marketing practices include: misrepresentation; unfair inducements; unfair discrimination; restraint of competition, unfair restriction of contracting parties' choice of insurer; extra charges; attempt to unduly influence employers; and unfair use of official position.

[s. 628.34, ss. Ins 6.54, 6.55]

WHAT IS MISREPRESENTATION?

It is a violation for intermediaries and their employees or those acting on their behalf to make any written or oral communication about any insurance contract, the insurance business, any insurance company, or any agent which contains false or misleading information. This includes:

- Giving information which is not complete and is misleading because of being incomplete;
- Filing a report with the intent to deceive the person examining that report;
- Making a false entry in a record;
- Failure to make a proper entry in a record for the purpose of concealing information; and
- Using the name, slogan, emblem, or related device which will or is likely to cause an intermediary to be mistaken for another intermediary in the insurance business. If an insurance intermediary distributes cards or documents, exhibits signs, or publishes advertisements which include misrepresentations and contain reference to a particular insurer that the person represents as agent, the intermediary's violation carries a presumption that the violation was also committed by the insurer.

[s. 628.34(1)]

WHAT IS UNFAIR INDUCEMENT?

No insurance company, employee, or intermediary may influence another person to buy an insurance policy or to end a present insurance policy by offering benefits not set out in the policy. The insurance company may not make any agreements not written in the policy. This does not apply to reducing the amount of premiums because of expense savings, including commission reductions, resulting from any form of mass marketing.

No intermediary, broker, or insurer may absorb the premium tax for unauthorized insurance purchased under s. 618.43, Wis. Stat., for which the policyholder is responsible.

[ss. 628.34(2), 618.43(2)]

WHAT IS UNFAIR DISCRIMINATION?

No insurance company may charge different policyholders different premiums or provide different terms of coverage, unless the differences are based on classifications which relate to the nature and degree of risk covered or the expenses involved. Rates do not discriminate unfairly if they are averaged among the persons covered under a group, blanket, or franchise policy. Terms of a group or blanket policy are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

[s. 628.34, ss. Ins 6.54, 6.55, 6.67, 6.68]

WHAT IS RESTRAINT OF COMPETITION?

It is illegal for any of the following persons to commit or agree to take part in any act of boycott, coercion, or intimidation which tends to unreasonably restrain the business of insurance, or which tends to create a monopoly in the insurance business:

- A person who is or should be licensed in Wisconsin;
- A person who is an employee or agent of the person who is or should be licensed in Wisconsin;
- A person whose main interest is to compete in the same business as those persons who are or should be licensed in Wisconsin;
- A person who acts on behalf of those persons mentioned in the preceding sections.

[s. 628.34(4)]

MAY A PERSON'S CHOICE OF INSURER BE RESTRICTED BY ANOTHER?

No one who requires insurance coverage as a condition for concluding a contract or for exercising any right under a contract may restrict the choice of insurer of the person buying the coverage. The person who is requiring the coverage may reserve the right to disapprove, on reasonable grounds, the policy or insurance company selected. The form of the corporate organization of the insurance company is not a reasonable ground for disapproval.

[s. 628.34(5)]

WHAT ABOUT "EXTRA CHARGES"?

No person may make any charge other than premiums and premium financing charges for the protection of property or protection of a security interest in property, when the charge is a condition for the financing of a purchase of the property or the lending of money on the security of an interest in the property.

[s. 628.34(6)]

WHAT ABOUT RESTRICTIONS ON THE USE OF OFFICIAL POSITIONS TO INFLUENCE THE PURCHASE OF INSURANCE?

No one holding a position in government may use decision-making power to coerce a person to purchase an insurance policy from a particular intermediary or insurance company. Affected positions include elective, appointive, or civil service positions in federal, state, or local governments.

[s. 628.34(8)]

WHAT ABOUT INFLUENCING EMPLOYERS?

No insurance company or intermediary or employee or agent may, in connection with an insurance transaction, influence or attempt to influence any employer not to hire a person or to fire a person arbitrarily or unreasonably.

[s. 628.34(7)]

MUST AN INTERMEDIARY RETURN INDICIA OF AGENCY (CHARACTERISTIC MARKS, TOKENS, MATERIALS, ETC.) WHICH INDICATE THAT THE INTER- MEDIARY REPRESENTS A PARTICULAR INSURER?

No agent may refuse or fail to return promptly all indicia of agency to any insurance company he or she represents whenever the company demands it.

[s. 628.34(9)]

ARE THERE ADDITIONAL RULES DEFINING UNFAIR MARKETING PRACTICES?

The Commissioner may define by administrative rule specific unfair trade practices after a finding that the practices are misleading, deceptive, unfairly discriminatory, provide an unfair inducement, or restrain competition unreasonably.

Some current rules which define unfair trade practices are:

- Section Ins 2.07, Wis. Adm. Code, replacement of life insurance policies: disclosure requirements;
- Section Ins 2.08, Wis. Adm. Code, special policies and provisions: prohibitions, regulations, and disclosure requirements;
- Section Ins 2.09, Wis. Adm. Code, separate and distinct representations of life insurance;
- Section Ins 2.12, Wis. Adm. Code, exceptions to unfair discrimination;
- Section Ins 2.14, Wis. Adm. Code, life insurance solicitation;
- Section Ins 2.15, Wis. Adm. Code, annuity benefit solicitation;

- Section Ins 3.26, Wis. Adm. Code, unfair trade practices in credit life/credit accident and health insurance;
- Section Ins 3.27, Wis. Adm. Code, advertisements of and deceptive practices in accident and health insurance;
- Section Ins 3.29, Wis. Adm. Code, replacement of accident and health insurance;
- Section Ins 6.09, Wis. Adm. Code, prohibited acts by captive agents of lending institutions and others;
- Section Ins 6.54, Wis. Adm. Code, prohibited classification of risks for rating purposes;
- Section Ins 6.55, Wis. Adm. Code, discrimination based on sex—unfair trade practice;
- Section Ins 6.67, Wis. Adm. Code, unfair discrimination in life and disability insurance based on physical or mental impairment or sexual orientation;
- Section Ins 6.68, Wis. Adm. Code, unfair discrimination based on geographic location or age of risk.

[s. 628.34]

EXAMPLES

Are the following cases unfair marketing practices?

- An agent licensed to sell accident and health insurance in Wisconsin sold a policy to a 77-year-old man. During the course of the agent's sales presentation, the agent told the man that his company offers a medicare supplement policy which paid every expense not covered by medicare. According to the agent, the policy would "fill all the gaps" in the medicare coverage. Is that an unfair marketing practice?

Yes. Under s. 628.34 (1), Wis. Stat., the agent violated the law by telling the man that the insurance policy completely supplemented the coverage provided by medicare. There is no supplement policy which pays every expense not covered by medicare. The statute applies because the agent was licensed, the information given the man was false and misleading, and the information communicated concerned an insurance contract. Under s. 628.34 (11), Wis. Stat., the Commissioner has defined additional unfair trade practices in the insurance code regulations. The agent's false statement about this policy filling "all the gaps" in medicare was also a violation of s. Ins 3.27 (9) (n), Wis. Adm. Code. (See also s. Ins 3.39, Wis. Adm. Code, for medicare supplement regulations.)

- A licensed intermediary told a customer that her present accident and health insurance coverage was "almost worthless," that the company was financially unsound, and its agents were "crooks"?

Yes. Under s. 628.34 (1), Wis. Stat., this amounts to a flagrant violation, assuming that the allegation is unprovable. These unfair disparaging remarks are a specific violation of s. Ins 3.27 (23), Wis. Adm. Code.

- A licensed intermediary, after identifying himself as a representative from the Social Security Administration, told the customer that he was there to explain medicare when he was really there to sell insurance?

Yes. Under s. 628.34 (1), Wis. Stat., this information is false and misleading. The false information concerning identification is a specific violation of s. Ins 3.27 (12) (c), Wis. Adm. Code.

- An individual intermediary licensed to sell automobile liability insurance handed out business cards identifying herself as an agent for an insurance company which she did not represent.

Yes. This is a violation of s. 628.34 (1), Wis. Stat. No intermediary may use any business name, slogan, emblem, or related device which is misleading or likely to cause the intermediary to be mistaken for another intermediary or insurer already in business.

- A licensed intermediary informed a customer that the fire insurance policy he was selling had been endorsed by the Governor and the state?

Yes. This is a clear violation of s. 628.34 (1), Wis. Stat.

- An intermediary licensed to sell life insurance told a customer that his company had taken over for the customer's present insurance company, and that now the customer must purchase new whole life insurance?

Yes. This is a clear violation of s. 628.34 (1), Wis. Stat. While there may be replacement of life insurance policies under s. Ins 2.07, Wis. Adm. Code, the above remarks are false and misleading, because an insurer cannot cancel all of its whole life policies.

- An individual intermediary licensed to sell accident and health policies represented to the customer that her company's disability policy "guarantees your income"?

YES. This is misleading under s. 628.34 (1), Wis. Stat., and is clearly forbidden under s. Ins 3.27 (9) (n), Wis. Adm. Code. However, such statements may be preceded by other words such as "help."

WHAT EFFECT DOES THE INTERMEDIARY'S APPOINTMENT HAVE ON THE INSURER?

Every insurer is bound by an act of its agent performed in Wisconsin that is within the scope of the agent's authority. The insurance company remains bound while the agency contract is in force or until the insurance company has made reasonable efforts to recover from the agent its policy forms and other indicia of the agency. Reasonable efforts shall include a formal demand in writing for return of the indicia, and notice to the Commissioner if the agent does not comply with the demand promptly.

[s. 628.40]

COMPENSATION OF INTERMEDIARIES

MAY AN INTERMEDIARY RECEIVE COMPENSATION FOR INSURING HIMSELF OR HIS PROPERTY? (CONTROLLED BUSINESS)

No intermediary may receive any compensation from an insurer for procuring insurance upon the intermediary's own property, life, or other risk unless during the prior year the intermediary sold other insurance with the same insurance company with total premiums exceeding the premiums on the intermediary's own risks.

[s. 628.51]

MAY AN AGENT RECEIVE COMPENSATION FROM AN INSURED OR FROM AN INSURED AND ANOTHER SOURCE FOR THE PURCHASE OF INSURANCE OR FOR RENDERING ADVICE ON INSURANCE NEEDS AND COVERAGES?

Yes, an agent may accept compensation under these circumstances. However, the agent must disclose to the applicant in writing:

- The amount of compensation to be paid by the insured (other than a commission payment made by the insurer); and
- The fact, if applicable, that compensation will be paid by another source.

[s. 628.32]

WHAT ABOUT SHARING COMMISSIONS?

No intermediary or insurance company may pay any consideration, or reimburse out-of-pocket expenses, to any person for services performed within Wisconsin as an intermediary if they know or should know that the person getting paid is not licensed.

No person may accept compensation for services performed as an intermediary unless the person is licensed under Wisconsin law.

An intermediary may direct that his or her commissions be paid to a partnership or corporation of which the intermediary is a member, officer, employee, or agent.

The law does not prohibit the payment of deferred commissions to formerly licensed agents or brokers or their assignees. The law also does not prohibit the proper exchange of business between intermediaries and brokers lawfully licensed in Wisconsin.

[s. 628.61]

**MAY AN AGENT BE COMPENSATED FOR REFERRING BUSINESS TO
ANOTHER INTERMEDIARY (PROPER EXCHANGE OF BUSINESS)?**

Proper exchange of business means the forwarding of insurance business from one agent to another because the forwarding agent is not able to place the business with any of the companies for which the agent is listed due to capacity problems, the refusal of the company to accept the risk or the onerous conditions it imposes on the insured. The agent forwarding the business is entitled to split the commission involved. Proper exchange of business is distinguished from brokerage by its occasional and exceptional nature.

An agent may properly exchange business with another agent or broker only if:

- The agent forwarding the business is licensed in the same line of business that is being exchanged;
- The agent who receives the business and agrees to place it is licensed in the line of insurance involved in the exchange; and
- The agent forwarding the business and the agent who places the business with the insurer both sign the insurance application, or if no application is completed, the names of both agents involved in the transaction appear on the policy.

In the absence of evidence to the contrary, an agent is presumed to have exceeded the occasional exchange of business if he or she places more than five insurance risks per calendar year with any single insurer with which he or she is not listed as an agent, or exchanges in total more than 25 insurance risks per calendar year.

[s. Ins 6.66]

CHAPTER III

INSURANCE CONTRACTS GENERALLY

This chapter covers insurance contracts in general. The state statutes affecting this material (chs. 631 and 632, Wis. Stat.) set out minimal standards for regulating the terms of insurance contracts. Control over policy forms and provisions is necessary for the adequate protection of Wisconsin policyholders. The approach of these statutes is to establish explicit standards within which the intermediary and the insurer will have sufficient freedom to develop contract terms and alternatives that fill the needs of individual consumers.

GENERAL RULES

DO CHS. 631 AND 632, WIS. STAT. (the "Contracts" chapters), APPLY TO ALL KINDS OF INSURANCE?

The laws and regulations in these chapters apply to all insurance policies delivered or issued for delivery in this state on:

- Persons residing in Wisconsin when the policy is issued;
- Property ordinarily located in Wisconsin; or
- Business operations in Wisconsin.

[s. 631.01(1)]

ARE THERE EXCEPTIONS?

Unless otherwise specified by order or rule, chs. 631 and 632, Wis. Stat., do not apply to:

- Death and disability benefits provided by an organization the principal purpose of which is not to provide such benefits but to seek unrelated charitable, educational, social, or religious objectives if the organization does not incur a legal obligation to pay a specified amount;

[s. 600.01(1)(b)2]

- Group or blanket insurance covering risks in Wisconsin if both the policyholder and the group do not exist primarily to procure insurance, the policyholder is not a Wisconsin resident and does not have its principal office in Wisconsin, fewer than 25% of the insureds are Wisconsin residents, and certain legal requirements are met;

[s. 600.01(1)(b)3]

- Transactions independently procured through negotiations involving direct placement of insurance with unauthorized insurers in compliance with s. 618.42, Wis. Stat.;

[s. 600.01(1)(b)6]

- Business operations in Wisconsin if the contract is negotiated outside this state and if the operations in Wisconsin are incidental or secondary to operations outside Wisconsin;

[s. 631.01(1)(b)]

- Reinsurance and ocean marine insurance except for certain specific statutes; and

[ss. 631.01(2), (3)]

- Group policies and annuities for eleemosynary institutions (that is, educational, research, religious, or charitable organizations licensed under ch. 615).

[s. 631.01(4)]

The Commissioner may by rule exempt any class of insurance or insurance company from any or all provisions of chs. 631 and 632, Wis. Stat., if the interests of Wisconsin policyholders, creditors, or the public do not require such regulation.

[s. 631.01(5)]

ARE BINDERS AND ORAL CONTRACTS FOR INSURANCE VALID?

The insurance laws of Wisconsin do not forbid an oral contract of insurance or issuance of a written promise to provide coverage. The insurance company must issue a policy as soon as reasonably possible after negotiation of an oral contract or issuance of any binder.

[s. 631.05]

MAY A POLICY BE ISSUED TO A PERSON WHO DOESN'T HAVE AN "INSURABLE INTEREST" IN THE SUBJECT MATTER INSURED?

No insurance company may knowingly issue a policy to a person who does not have an insurable interest in the subject of the insurance.

A person has an insurable interest if the person would suffer a disadvantage or loss, especially a monetary loss, if that event should occur for which insurance is being considered. For example, the owners of a farm would have an insurable interest in their own property, but not normally in their neighbor's.

[s. 631.07(1)]

MAY A LIFE OR DISABILITY POLICY BE ISSUED TO ANYONE OTHER THAN THE PERSON WHOSE LIFE OR HEALTH IS BEING INSURED?

Except for the cases in the following section, an insurance company may only issue an individual life or disability insurance policy to the person whose life or health is being insured, unless the person who is being insured gives written consent to the policy being issued to another person. Consent is shown when the insured signs the insurance application with the knowledge it concerns insurance coverage on him or herself. Consent may also be expressed in any other reasonable way.

[s. 631.07(2)]

MAY A CHARITABLE ORGANIZATION PURCHASE OR OWN A LIFE INSURANCE POLICY ON THE LIFE OF AN INDIVIDUAL?

A charitable organization is deemed to have an insurable interest and may be the applicant, owner, or beneficiary of a life insurance policy, an endowment policy, or an annuity issued on the life of any individual. For policies issued on or after March 1, 1994, a charitable organization has an insurable interest only if it obtains the consent of the individual in writing or by other means authorized by common law or by statute.

[s. Ins 2.45]

ARE THERE CASES WHERE THE INSURED'S CONSENT TO LIFE OR DISABILITY INSURANCE IS UNNECESSARY?

A life or health disability policy may be taken out by a third party without consent in the following cases:

- A person may obtain insurance on a dependent who does not have legal capacity.
- A creditor at the creditor's own expense may obtain a life or disability policy on the debtor in an amount reasonably related to the amount of the debt.
- A person may obtain a life or disability policy on family members who live with the person or qualify as his or her dependents.
- A person may obtain a disability policy on others which would only cover expenses that the policyholder would be legally or morally obligated to pay.
- The Commissioner may make rules permitting policies for a limited period of time on the life or health of a person serving the federal government outside the continental United States, provided the policyholder is closely related by blood or by marriage to the person who is being insured.

[s. 631.07(3)(a)]

ARE THERE CASES WHERE CONSENT MAY BE GIVEN BY ANOTHER?

Consent may be given by another in the following cases:

- A parent, guardian, or a person having legal custody as defined in the statutes, may consent to the issuance of a policy on a dependent child;
- A grandparent may consent to the issuance of life or disability coverage on a grandchild;
- A court of general jurisdiction may consent when the facts shown are sufficient to justify such insurance.

[s. 631.07(3)(b)]

WHAT HAPPENS WHEN A POLICY IS ISSUED WHERE THERE IS NO INSURABLE INTEREST OR CONSENT?

No insurance policy is invalid because the policyholder lacks an insurable interest or because consent was not given. A court can order the policy's proceeds paid to someone other than the person who was to receive the proceeds. The court may order payment to a person who is equitably entitled to the proceeds. The court may also order the proceeds to be put in a constructive trust which would be subject to the remaining terms and conditions of the policy.

[s. 631.07(4)]

EXAMPLES

May the insurance company issue an insurance policy in the following cases?

- A and B are partners in a business. B is not a dependent of A, nor is A a creditor of B. May an insurance company issue A a policy on B's life without B's consent?

No. Under s. 631.07 (1), Wis. Stat., there is an insurable interest. Because of their business relationship, A has a reasonable expectation of monetary benefit from the continued life of B. However, written consent to the issuance of the policy is necessary and B failed to give such consent.

- An insurance company knowingly issued a fire insurance policy to A on B's house. On just these facts should the policy have been issued?

No. There is no indication of insurable interest.

- A is issued a disability policy on B. B is the husband of A. On these facts alone, may A be issued the policy?

Yes. Under s. 631.07 (2), Wis. Stat., consent is generally required for issuance of a life or disability policy on the life of another person. However, since B is a member of A's family and living with A, consent is not required.

WHAT IS THE LEGAL EFFECT OF A MISTAKE IN AN INSURANCE CONTRACT?

In most circumstances, unless otherwise provided, general contract law applies to mistakes in insurance contracts.

In property insurance, a mistake in designating the person to whom the insurance is payable does not void the policy. Such a mistake does not constitute a defense for the insurance company unless the mistake was due to misrepresentation or concealment by the owner of the property or by someone representing the owner in getting the policy, or unless the company would not have issued or continued the policy if it had known the truth.

[s. 631.08]

IS AN INSURANCE COMPANY RESPONSIBLE FOR INFORMATION KNOWN TO ITS AGENTS?

An insurance company is deemed to know any fact material to the risk or which violates a condition of the policy:

- If the insurance company's agent who bound the company, issued the policy or transmitted the application to the insurer knew the fact at the time he or she acted; or
- If afterwards any of the company's agents learned of the fact during the course of dealing with the policyholder as an agent and knew that the fact pertained to the policy.

[s. 631.09(1)]

WHAT IF THE INSURED FAILS TO PERFORM A REQUIRED ACT DUE TO THE ACTS OF THE AGENT?

If a policyholder or insured failed to perform a required act in the prescribed time or manner because of the agents' actions or statements, the failure does not affect the insurance company's obligations under the policy. This is the case whether or not the agent was within the actual scope of the agent's authority.

[s. 631.09(2)]

IS NOTICE TO AN AGENT NOTICE TO THE INSURANCE COMPANY?

The insurance company has been notified if the company's authorized agent has been notified and provided with sufficient information to identify the policy in question.

[s. 631.09(3)]

HOW IS THE INSURER PROTECTED FROM COLLUSION BETWEEN THE POLICYHOLDER AND AGENT?

If the agent and policyholder or insured acted together to deceive or defraud the insurance company, the sections on knowledge of the insurance company and acts of agents do not apply. The two sections also do not apply if the policyholder or the insured knew the agent was acting beyond the scope of the agent's authority.

[s. 631.09(4)]

WHAT IS A REPRESENTATION BY AN APPLICANT?

Representations are oral or written statements made by an applicant. Insurance coverage is issued on the basis of the applicant's representations.

[Common Law, s. 631.11]

WHAT IS MISREPRESENTATION BY AN INTERMEDIARY?

Misrepresentation by an intermediary is the use of written or oral statements which incorrectly describe the terms or benefits of any policy.

[Common Law, s. 631.11]

WHAT IS A MATERIAL MISREPRESENTATION BY AN APPLICANT?

A material misrepresentation is an untrue statement made by an applicant that would influence a prudent insurer in determining whether to accept the risk or in fixing the amount of the premium in the event of such acceptance.

[Common Law, s. 631.11]

WHAT IS A WARRANTY?

A warranty is a statement made in an insurance contract by the insured when the validity of the insurance contract depends on the literal truth of the statement. The parties to the contract mutually intend that the policy will not be binding unless the statement is true.

[Common Law, s. 631.11]

WHAT IS AN AFFIRMATIVE WARRANTY?

An affirmative warranty is an express or implied positive representation in the policy which affirms an existence of a fact at the time the policy was entered into.

[Common Law, s. 631.11]

WHAT IS A PROMISSORY WARRANTY?

A promissory warranty is a warranty that certain things will be done or not be done after the policy has taken effect.

[Common Law, s. 631.11]

WHEN DOES A STATEMENT, REPRESENTATION, OR WARRANTY AFFECT THE INSURER'S OBLIGATIONS UNDER A POLICY?

No statement, representation, or warranty made by a person other than the insurer or an agent of the insurer in the negotiation for an insurance contract affects the insurance company's obligations under the policy unless it is stated in any of the following:

1. The policy.
2. A written application signed by the person provided that a copy of the written application is made a part of the policy by attachment or endorsement.
3. A written communication provided by the insurer to the insured within 60 days after the effective date of the policy.

[s. 631.11(1)(a)]

MUST A COPY OF THE APPLICATION BE MADE AVAILABLE TO THE INSURED?

The policyholder under a life and disability insurance policy and any person whose life or health is insured under the policy may request in writing a copy of the application if he or she did not receive the policy or a copy of it. The request may also be made if the policy has been reinstated or renewed without attachment of a copy of the original application. If the insurance company does not deliver or mail a copy as requested within 15 working days after the company or its agent receives the request, nothing in the application may affect the insurance company's obligations under the policy to the person making the request. The same conditions and results apply where a group policy certificate holder is not informed by the insurer how such person may inspect the policy and application during normal business hours at a place reasonably convenient to the certificate holder.

[s. 631.11(4m)(a)]

WHAT IS THE EFFECT OF A MISREPRESENTATION OR BREACH OF AN AFFIRMATIVE WARRANTY ON THE INSURER'S OBLIGATIONS?

No misrepresentation, and no breach of an affirmative warranty, that is made by a person other than the insurer or an agent of the insurer in the negotiation for or procurement of an insurance contract constitutes grounds for rescission of, or affects the insurer's obligations under, the policy unless, if a misrepresentation, the person knew or should have known that the representation was false, and unless any of the following applies:

- The insurer relies on the misrepresentation or affirmative warranty and the misrepresentation or affirmative warranty is either material or made with intent to deceive.

[s. 631.11(1)(b)]

- The fact misrepresented or falsely warranted contributes to the loss.

WHAT EFFECT DOES THE INSURER'S KNOWLEDGE HAVE ON ITS OBLIGATIONS?

No misrepresentation made by or on the behalf of a policyholder and no breach of an affirmative warranty or failure of a condition constitutes grounds for rescission of, or affects an insurer's obligations under an insurance policy if at the time the policy is issued the insurer has either constructive knowledge of the facts (under s. 631.09 (1), Wis. Stat.) or actual knowledge. If the application is in the handwriting of the applicant, the insurer does not have constructive knowledge under s. 631.09, Wis. Stat., merely because of the agent's knowledge.

[s. 631.11(4)(a)]

If after issuance of an insurance policy an insurer acquires knowledge of sufficient facts to constitute grounds for rescission of the policy under this section or a general defense to all claims under the policy, the insurer may not rescind the policy and the defense is not available unless the insurer notifies the insured within 60 days after acquiring such knowledge of its intention to either rescind the policy or defend against a claim if one should arise, or within 120 days if the insurer determines that it is necessary to secure additional medical information.

[s. 631.11(4)(b)]

EXAMPLES

- An applicant for health insurance falsely told an agent that she had a physical examination recently which found her in excellent health. An insurance policy was issued. The application for insurance contained no questions relating to physical examinations. The policyholder submitted a claim under the policy six months later. May the insurance company rescind or void the policy on the grounds that the false statement induced the company to issue the policy?

No. While the status of the applicant's health is material to the risk and the insurer might rely on an applicant's stating that she is in good health in issuing the policy, in this case the statement was not written into the policy or application signed by the policyholder.

- An insurance application required the applicant to state whether the person ever had a previous automobile liability policy cancelled. The applicant falsely answered "no." The applicant suffered an automobile accident four months after the policy was issued and made a claim under the policy. Is the insurance company obligated to pay the claim?

Answer: The fact that a prior insurer had cancelled the person's liability policy may be material to the risk. The insurer relied upon the application statement in issuing the policy. The insurer might consider rejecting the claim, or rescinding or voiding the policy if it has complied with the requirements of s. 631.11 (1) (a), Wis. Stat. The insurer might also consider terminating the policy midterm because of material misrepresentation, as provided in s. 631.36 (2) (a), Wis. Stat.

WHAT IS "INCORPORATION BY REFERENCE"?

The term describes the practice of making one document a part of another document. Under this practice, the latter document contains a provision that the former document is to be considered part of the latter, or merely indicates that the former is incorporated by reference.

[Common Law, s. 631.13]

CAN SEPARATE AGREEMENTS OR OTHER MATERIALS BE "INCORPORATED BY REFERENCE" INTO A POLICY?

An insurance contract may not contain any agreement or incorporate any provision unless the provision is fully set forth in the policy, application, or document which is attached to and made part of the policy at the time of delivery. Exceptions are:

- Rates. Any policy may by reference incorporate rate schedules and classifications of risks and short-rate tables filed with the Commissioner; and

- Complex contracts. By rule or order or by approval of a form, the Commissioner may authorize incorporation by reference of provisions for administrative arrangements, premium schedules, and payment procedures in complex contracts.

[s. 631.13]

WHAT ARE THE MEDICAL RECORDS PRIVACY PROTECTIONS UNDER WISCONSIN INSURANCE LAW?

Wisconsin enacted a statute that regulates the disclosure of personal medical information. It places restrictions on both insurers and the persons that regularly assemble or collect personal medical information for the primary purpose of providing the personal medical information to insurers for the determination of an individual's eligibility for an insurance coverage, benefit or payment or for the servicing of an insurance application, policy or certificate. The law delineates the form that is to be used in obtaining authorization for release of personal medical information, the timeframe for which such information may be requested and maintained, how and to whom information may be re-released to other entities or health care providers, notice requirements to individuals or insureds and the right of the individual to request a correction, amendment or deletion of personal medical information that is in the insurer's possession.

[s. 610.70]

WHAT ARE THE PRIVACY PROTECTIONS REGARDING NON-PUBLIC PERSONAL FINANCIAL INFORMATION UNDER WISCONSIN INSURANCE LAW?

Wisconsin enacted rules that require insurance companies and agents to provide written notice of its privacy policies and practices. The rule describes the conditions under which insurance companies and their agents may disclose nonpublic personal financial information. The rule also establishes requirements for privacy notices.

The rule also establishes restrictions on the sharing of health information. However, as Wisconsin has a separate statute regarding Medical Records Privacy, the provisions of the rule apply primarily to health information relating to claimants against worker's compensation or commercial liability insurance policies.

[ch. Ins 25]

WHEN ARE AGENTS REQUIRED TO PROVIDE PRIVACY NOTICES?

Agents can rely on the notice procedures of the insurance companies they represent as long as the agent does not share the nonpublic personal information as provided by the rule. If the agent shares the information with third-parties in activities that are not excepted by the rule, the agent will be required to issue the same type of notices required of the insurer.

[ch. Ins 25]

DISPOSAL OF RECORDS CONTAINING PERSONAL INFORMATION

Wisconsin statutes include provisions regarding the proper disposal of personal medical information. The law is often referred to as the “dumpster diving law.” It requires that insurers that obtain information from an insured, or an individual seeking coverage, pertaining to the individual’s physical or mental health, medical history or medical treatment take specific steps to ensure that this personally identifiable information is shredded, erased, modified or otherwise handled so that no unauthorized person has access to the information.

[s. 895.505]

APPROVAL OF POLICY FORMS

MAY ANY INSURANCE POLICY FORM BE USED IN WISCONSIN?

Unless specifically exempt under the statutes, no policy form may be used in Wisconsin unless it has been filed with and approved by the Commissioner. It is deemed approved if it is not disapproved within 30 days after filing, or within a 30-day extension of that period ordered by the Commissioner prior to the expiration of the first 30 days.

[s. 631.20(1)]

MAY AN APPROVED POLICY FORM BE DISAPPROVED SUBSEQUENTLY?

After a hearing and a finding that a previously approved form would be disapproved for one of the reasons set out in s. 631.20 (2), Wis. Stat., if newly filed, the Commissioner may order use of the form discontinued or the appropriate changes made.

[s. 631.20(3)]

WHAT ARE THE READABILITY STANDARDS FOR INSURANCE POLICIES?

A rule relating to the readability of insurance policies went into effect in Wisconsin in 1980. The rule implements s. 631.22, Wis. Stat.

The rule applies to consumer insurance policies issued or delivered in Wisconsin. Consumer insurance policies are defined as life, disability, property or casualty policies and certificates or substitutes for certificates for group life, disability, property or casualty insurance coverage, issued for family, personal, or household purposes. There are some exemptions.

Minimum standards for approval are:

- There must be a minimum score of 40 on the Flesch reading ease test or an equivalent score on a comparable test. (The minimum Flesch score for medicare supplement policies is 50.)

- Except for specification pages, schedules, and tables, the policy must be printed in 10-point type.
- The policy must be appropriately divided and captioned and be presented in a meaningful sequence, and its overall appearance must enhance its understandability.
- A table of contents or index may be required.
- Exclusions must be clearly set out.
- Definitions are required where appropriate.
- Cross-referencing between sections must be minimized.

When policies subject to the rule are submitted for approval, they must be accompanied by a certification stating that the policy meets the minimum standards.

[s. 631.22, s. Ins 6.07]

SPECIFIC CLAUSES IN CONTRACTS

WHEN IS MID-TERM CANCELLATION OF POLICIES PERMISSIBLE BY INSURERS?

Except for new policies and umbrella or excess liability policies as defined in s. Ins 6.77, Wis. Adm. Code, no insurance policy may be cancelled by the insurer prior to the expiration of the agreed term or one year from the effective date of the policy or renewal, whichever is sooner, except for:

- Failure to pay a premium when it is due; or
- Grounds for cancellation which are stated in the policy that are included within the following classes:

Material misrepresentation;

Substantial change in the risk assumed, except to the extent that the insurer should have reasonably foreseen the change or contemplated the risk in writing the contract;

Substantial breaches of contractual duties, conditions, or warranties; or

Attainment of the age specified as the terminal age for coverage, in which case the insurer may cancel by notice accompanied by a pro rata return of the premium.

[s. 631.36(2)(a), ss. Ins 6.77, 21.01(4)(a)]

WHAT KIND OF NOTICE IS REQUIRED IN MID-TERM CANCELLATION?

No cancellation based on the grounds listed in the above section is effective until at least 10 days after the first class mailing or delivery of a written notice to the policyholder.

For worker's compensation insurance, no cancellation based on the grounds listed in the above section is effective until at least 30 days after the 1st class mailing or delivery of a written notice to the policyholder. However, the cancellation is effective whether or not the notice has been given to the policyholder upon the effective date of replacement insurance coverage obtained by the employer or of an order exempting the employer from carrying worker's compensation insurance.

[ss. 102.31(2)(a), (2)(b)1, 631.36(2)(b), s. Ins 21.01(4)(b)]

WHAT ABOUT MID-TERM CANCELLATION OF NEW POLICIES?

The permissible grounds for mid-term cancellation and the notice requirements listed above do not apply to any new insurance policy which has been in effect less than 60 days at the time the notice of cancellation is mailed or delivered. No cancellation is effective until at least 10 days after the first class mailing or delivery of a written notice to the policyholder. This cancellation notice need not contain information about the grounds for cancellation unless it is a health insurance policy and the cancellation would affect eligibility for the Wisconsin Health Insurance Risk Sharing Plan (HIRSP).

For worker's compensation insurance, no cancellation is effective until at least 30 days after the 1st class mailing or delivery of a written notice to the policyholder. However, the cancellation is effective whether or not the notice has been given to the policyholder upon the effective date of replacement insurance coverage obtained by the employer or of an order exempting the employer from carrying worker's compensation insurance.

[ss. 102.31(2)(a), 631.36(2)(c), ss. Ins 18.10, 21.01(4)(c)]

WHAT ABOUT "ANNIVERSARY" CANCELLATIONS?

A policy may be issued for a term longer than one year or for an indefinite term with a clause providing for cancellation by the insurer by giving notice 60 days prior to the anniversary date. The notice must comply with the statutory requirements for nonrenewals.

[ss. 102.31(2)(a), (2)(b)1, 631.36(3), (4), s. Ins 21.01(5)]

Insurers are required to give specific medical reasons when cancelling health insurance policies because of the insured's health condition.

[s. Ins 18.10]

WHAT NOTICE IS REQUIRED IF A POLICY IS NOT RENEWED?

Subject to the statutory requirements for midterm and anniversary cancellations, a policyholder has the right to have his or her policy renewed, on the terms then being applied by the insurer to similar risks, for an additional period of time equal to the last term

if the last term was a year or less, or for one year if the last term was longer than one year. The policy must be renewed unless at least 60 days before the expiration date, a notice of intent not to renew the policy is mailed or delivered to the policyholder. The notice of nonrenewal to be effective must state with reasonable precision the fact on which the insurer's decision is based.

To nonrenew because the policyholder did not pay the renewal premium on time, the insurer must give written notice to the policyholder, between 10 and 75 days before the premium is due and the notice must clearly state the effect of nonpayment of premium by the due date. For worker's compensation insurance, to nonrenew because the policyholder did not pay the renewal premium on time, the insurer must give written notice to the policyholder between 30 and 75 days before the premium is due and the notice must clearly state the effect of nonpayment of premium by the due date.

This provision does not apply if the policyholder has insured elsewhere, has accepted replacement coverage or has requested or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable. For worker's compensation insurance, a nonrenewal is effective whether or not the notice has been given to the policyholder upon the effective date of replacement insurance obtained by the employer or of an order exempting the employer from carrying worker's compensation insurance.

[ss. 102.31(2)(a), (2)(b)1, 631.36(4), (6), s. Ins 21.01(6)]

WHAT HAPPENS WHEN AN INSURER OFFERS TO RENEW AT ALTERED TERMS?

If the insurance company offers to renew the policy on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date if the insurer sent by 1st class mail or delivered to the policyholder notice of the new terms or rates at least 60 days prior to the expiration date. If the insurer has not so notified the policyholder, the new terms or rates do not take effect until 60 days after the notice is mailed or delivered, in which case the policyholder may elect to cancel the renewal policy at any time during the 60-day period. Return premiums or additional premium charges shall be calculated proportionately on the basis of the old rates. This section does not apply if the only change is a rate increase of less than 25% that either is generally applicable to the class of business to which the policy belongs or results from a classification change based on the altered nature or extent of the risk insured against.

[s. 631.36(5)]

The insurer is prohibited from issuing or renewing a policy that is less favorable to the insured or cancelling or nonrenewing a policy because of any accident that occurs in the course of the insured's business or employment unless the policy covers the insured for liability that arises in the course of his or her employment or business.

[ss. 632.36(1)(title), (2)]

CAN AN INSURANCE COMPANY NONRENEW A POLICY SOLELY BECAUSE OF THE TERMINATION OF AN INSURANCE MARKETING INTERMEDIARY'S CONTRACT WITH THE INSURER?

An insurer may refuse to renew or cancel a policy, subject to the statutory requirements for nonrenewals and anniversary cancellations, only if the notice of nonrenewal or cancellation contains an offer to continue to renew the policy with the insurer if the insurer receives a written request from the policyholder prior to the cancellation or renewal date. The insurer will continue or renew the policy if a timely request is received unless the policyholder does not meet normal underwriting criteria. For worker's compensation insurance, the cancellation or nonrenewal is effective whether or not the notice contains an offer to continue or renew the policy upon the effective date of replacement insurance obtained by the employer or of an order exempting the employer from carrying worker's compensation insurance.

[s. 631.36(4)(am), (4m), s. Ins 21.01(6)(b), (7)]

WHAT INFORMATION MUST A NOTICE OF CANCELLATION CONTAIN?

A notice of nonrenewal must state with reasonable precision the facts on which the insurer's decision was based. The notice of nonrenewal is not effective unless it contains adequate information. If a risk-sharing plan exists for the kind of coverage being cancelled, the notice must contain adequate instructions to the policyholder on how to apply for coverage in the plan.

This requirement does not apply if the ground for cancellation or nonrenewal is nonpayment of the premium.

[s. 631.36(6), (7), (8), s. Ins 21.01(8), (9), (10)]

IS THERE ANY LIABILITY FOR MAKING STATEMENTS OR PROVIDING INFORMATION RELATING TO THE REASONS FOR TERMINATION?

There is no liability on the part of and no cause of action arises against any insurer, its authorized representatives, its agents, its employees, or any firm, person or corporation furnishing information relating to the reasons for cancellation or nonrenewal made to comply with s. 631.36, Wis. Stat.

[s. 631.36(9), s. Ins 21.01(11)]

EXAMPLES

- An insurance company notified policyholder "B" at least 60 days before the policy's date of expiration that the homeowner's policy would not be renewed. The notice only informed "B" that the policy would not be renewed. Was the cancellation effective?

No. Under s. 631.36 (6) and (7), Wis. Stat., the company must inform "with reasonable precision the facts on which the insurer's decision is based" and did not contain information on how to apply to the Wisconsin Insurance Plan.

WHAT HAPPENS WHEN TWO OR MORE POLICIES INDEMNIFY AGAINST THE SAME LOSS?

When two or more policies promise to indemnify an insured against the same loss, the total protection of the insured will be the lesser of the actual insured loss suffered by the insured or the total indemnification promised by the policies if any "other insurance" provisions are ignored.

The extent to which each is primary and each excess may be defined in the policies. If the policies contain inconsistent terms on that point, the insurers are jointly and severally liable to the policyholder on any coverage where the terms are inconsistent, each to the full amount of coverage it provided. Settlement among the insurers does not alter any rights of the insured. This does not affect the right of the insurance company to defend against a claim under the policy on the ground of fraudulent misrepresentation.

[s. 631.43]

WHAT ABOUT NONWAIVER CLAUSES IN POLICIES?

An insurance company may insert in any insurance policy a provision that no change in the policy is valid unless the change is approved by an executive officer of the insurance company and endorsed on the policy or attached to it. A provision may also be inserted which provides that an agent has no authority to change the policy or waive any of its provisions. These clauses do not preclude a person claiming a right under a policy from relying on waiver or estoppel in an appropriate case.

[s. 631.48]

WHAT NOTICE AND PROOF OF LOSS REQUIREMENTS APPLY TO THE INSURED?

If a proof of loss is furnished to the insurer as soon as reasonably possible and within one year after the time it was required by the policy, failure to furnish such notice or proof within the time required by the policy does not invalidate or reduce a claim unless the insurer is harmed as a result and it was reasonably possible to meet the time limit.

The notice or proof of loss is sufficient if it is properly mailed to the insurer within the time prescribed. The Commissioner may expressly approve clauses requiring more prompt and efficient methods of notice where that is reasonable.

The acknowledgment by the insurer of the receipt of notice, the furnishing of forms for filing proofs of loss, the acceptance of such proofs, or the investigation of any claim are not alone sufficient to waive any of the rights of the insurer in defense of any claim arising under the insurance contract.

[s. 631.81]

INSURANCE CLAIMS

ARE THERE STANDARDS FOR INSURANCE CLAIM SETTLEMENT PRACTICES?

Wisconsin law regulates insurance claim settlement practices in order to promote the fair and equitable treatment of policyholders, claimants, and insurers by defining certain claim adjustment practices as unfair business methods and practices in the insurance business.

[s. 628.46, s. Ins 6.11]

ARE THERE STANDARD FORMS THAT PROVIDERS AND INSURERS MUST USE WHEN SUBMITTING AND PAYING HEALTH INSURANCE CLAIMS?

Yes. The Wisconsin Administrative Code requires individual and institutional providers to use standardized billing forms for health care services. When an insurer pays a claim to a health care provider, the insurer is required to use a standardized remittance advice form and use the claim disposition codes of the American National Standards Institute. Although there is no standard format for explanation of benefits forms which are sent to insureds, insurers are required to include certain minimum information on such forms. Insurers are not required to provide an explanation of benefits if the insured has no liability for payment or is liable only for a copayment unless one is requested by the insured.

[ss. Ins 3.65, 3.651]

HOW PROMPTLY MUST CLAIMS BE PAID?

Unless otherwise provided by Wisconsin law, subject to interest payment, an insurer must promptly pay most insurance claims. A covered claim is overdue if not paid within 30 days after the insurer is furnished with a written notice of the fact of covered loss and the amount of loss.

If the written notice of the entire claim is not sent to the insurer, any partial amount supported by written notice is overdue if not paid within 30 days. A payment is not overdue if the insurer has reasonable proof to establish that the insurer is not responsible for the payment, even when written notice has been furnished to the insurer.

The date of payment is the date a check or payment was properly mailed or, if not mailed, the date of delivery of the payment. All overdue payments are charged simple interest at the rate of 12% per year.

The payment of a claim is not overdue until 30 days after the insurer receives the proof of loss required under the policy or equivalent evidence. Also, a delay in payment may be justified if the insurer cannot determine to whom the claim should be paid.

[s. 628.46]

WHAT ARE SOME EXAMPLES OF UNFAIR CLAIM SETTLEMENT METHODS AND PRACTICES?

Any of the following done without just cause and with such regularity as to indicate a general business practice, constitutes an unfair method and practice:

[s. Ins 6.11(3) for additional examples]

- Failure to acknowledge promptly pertinent communications with respect to claims arising under insurance policies;
- Failure to promptly provide the necessary claim forms, instructions, and reasonable assistance to insureds and claimants;
- Failure to attempt in good faith to effectuate fair and equitable settlements of claims in which liability has become reasonably clear;
- Knowingly misrepresenting to claimants pertinent facts or policy provisions.

[s. Ins 6.11]

IS SEX DISCRIMINATION AN UNFAIR TRADE PRACTICE?

The Wisconsin Administrative Code forbids the act of denying benefits or refusing coverage on the basis of sex, and seeks to eliminate unfair discrimination in underwriting criteria based on sex. In addition, the code seeks to eliminate differences in rates based on sex which cannot be justified by credible supporting information.

The following prohibitions apply to all insurance contracts delivered or issued in Wisconsin and are prohibited as unfair trade practices:

- The insurer may not refuse or cancel coverage or deny benefits on the basis of the sex of the applicant or insured;
- The insurer may not restrict, modify, or reduce the benefits, term, or coverage on the basis of the sex of the applicant or insured.

[s. Ins 6.55]

EXAMPLES

The following are examples of unfair trade practices due to sex discrimination:

- Denying coverage to females gainfully employed at home, employed part-time, or employed by relatives when coverage is offered to males similarly employed;
- Denying benefits offered by policy riders to females when the riders are available to males;
- Treating complications of pregnancy differently from any other sickness under a contract;

- Restricting, reducing, modifying, or excluding benefits payable for treatment of the genital organs of only one sex;
- Offering lower maximum monthly benefits to women than to men in the same underwriting, earnings, or occupational classifications under a disability income contract;
- Offering more restrictive benefit periods and more restrictive definitions of disability to women than to men in the same underwriting, earnings, or occupational classifications under a disability income contract; and
- Establishing different conditions by sex under which the policyholder may exercise benefit options contained in the contract.

[s. Ins 6.55]

SURPLUS LINES AND UNAUTHORIZED INSURANCE

(In this section note the difference between an "unauthorized insurer" and "unauthorized insurance.")

WHAT IS SURPLUS LINES INSURANCE?

Generally, surplus lines insurance is insurance placed with unauthorized (nonlicensed) insurers by an intermediary licensed to transact surplus lines business in Wisconsin. The license required is in addition to the regular intermediary license. The license fee is \$100.00 annually.

An insurer which has not obtained a certificate of authority to do business in Wisconsin may negotiate and make insurance contracts with persons in Wisconsin on risks in Wisconsin subject to the following limitations and requirements.

A nondomestic insurer (that is, an insurer domiciled in another state) is not permitted to advertise or solicit business in Wisconsin without a certificate of authority. However, the Commissioner has prescribed by rule the manner in which intermediaries may advertise the availability of their services in procuring, on the behalf of persons seeking insurance, contracts with insurers not holding a certificate of authority. Such advertisements may not refer to any particular unauthorized insurer or insurers.

The nondomestic unauthorized insurer may also inspect risks to be insured, collect premiums and adjust losses, and do all other acts reasonably incidental to a legally issued contract.

The unauthorized insurer and the intermediary are obligated promptly to furnish the policyholder with a proposal form which includes a statement that the insurer has not obtained a certificate of authority to do business in Wisconsin and is not state-regulated

except for s. 618.41, Wis. Stat. The proposal is set forth in s. Ins 6.17, Wis. Adm. Code. The policyholder must pay the 3% premium tax required under s. 618.43, Wis. Stat. The agent is required to keep all taxes collected in a separate bank account and not commingled with other funds.

Nothing in the law prohibits proper exchange of business in accordance with s. Ins 6.66, Wis. Adm. Code, between licensed intermediaries. A "regular" licensed intermediary may procure surplus lines policies through a licensed surplus lines intermediary and the surplus lines intermediary may share commissions with the "regular" agent, as spelled out in s. Ins 6.66, Wis. Adm. Code.

[s. 618.41, 618.43, ss. Ins 6.17, 6.66]

WHAT IS "DIRECT PLACEMENT" OF INSURANCE WITH UNAUTHORIZED INSURERS?

Generally, direct placement is accomplished when there is no Wisconsin intermediary or broker involved and negotiations occur primarily outside Wisconsin. It should be noted that the law provides that negotiations occur within Wisconsin if a letter regarding the insurance is sent to or from an address in Wisconsin.

Every policyholder who procures or renews insurance from any insurer not authorized to do business in Wisconsin, other than insurance procured under surplus lines insurance law and the renewal of guaranteed renewable insurance lawfully issued outside Wisconsin, must report within 60 days after the procurement or renewal to the Commissioner on the form required by s. Ins 6.19, Wis. Adm. Code. In addition, the policyholder must pay the tax as set out in s. 618.43, Wis. Stat.

A Wisconsin intermediary or broker need not be greatly concerned with directly placed insurance except to recognize that the law does permit Wisconsin residents to purchase insurance from any insurer, regardless of the reliability or authority of the insurer, provided the transaction takes place primarily outside the state of Wisconsin.

[ss. 618.42, 618.43, s. Ins 6.19]

WHAT IS "UNAUTHORIZED INSURANCE"?

Unauthorized insurance is that insurance placed with an unauthorized insurer illegally; in other words, not placed as a surplus lines transaction and not as a proper "direct placement" as explained above.

A person may not do an insurance business in Wisconsin if the person knows or should know that the result is or might be the illegal placement of insurance with an unauthorized insurer or the subsequent servicing of an insurance policy illegally placed with an unauthorized insurer.

Any person who commits an act which constitutes a violation under the above paragraph is personally liable to any claimant under the policy for any damage caused by the person's

violation. That damage may include damage resulting from the necessity of replacing the insurance with an authorized insurer or the failure of the unauthorized insurer to adhere to the contract.

[s. 618.39]

WHAT ABOUT RISK PURCHASING AND RISK RETENTION GROUPS?

A risk purchasing group is a group of members who engage in businesses or activities that expose the members to similar risks, form a group, and purchases liability insurance for the group.

An agent may not solicit, negotiate, or obtain liability insurance for a risk purchasing group from an unauthorized insurer unless the agent is a licensed surplus lines agent.

[s. 618.41(7m)]

A risk retention group is an insurance company comprised of members who engage in businesses or activities that expose the members to similar risks, which provides liability insurance to its members

An agent may not place insurance with or solicit the purchase of insurance from an unauthorized risk retention group if:

- The group is financially unsound, engages in unfair business practices, or is otherwise substandard;
- The agent fails to give the applicant written notice of the insurer's deficiencies; and
- The agent knows of or fails to investigate adequately the insurer's financial condition and general reputation.

[s. 618.41(8)]

Before taking an application for liability insurance under a policy issued by an unauthorized risk retention group, the agent must inform the applicant of the insurer's deficiencies, that the insurer is not regulated by the state, that the risk is not protected by the security fund, and any other information required by the Commissioner by rule.

[s. 618.415]

MUST INSURERS NOTIFY POLICYHOLDERS OF THEIR RIGHT TO FILE A COMPLAINT?

Yes. Insurers are required to notify their insureds of their right to file a complaint with the Office of the Commissioner of Insurance regarding problems they may have with their insurance. The notice is required once for each policy or certificate issued by an insurer.

[s. 631.28, s. Ins 6.85]

CHAPTER IV

DISABILITY INSURANCE

Disability insurance, previously labeled as "accident and health" insurance, is generally defined as any type of insurance which covers policy claims involving: (1) medical and surgical expenses; (2) indemnities for loss of income due to accident or health; (3) accidental death and disability; (4) hospital care; and (5) long-term care.

Most of the disability policies available offer a wide range of coverages and limits. The Commissioner has the authority to regulate the terms of insurance contracts to protect the policyholder. The insurance laws establish statutory standards, explicit enough to protect the insured and to give the Commissioner authority to set specific standards and provisions through rule-making powers.

DISABILITY

DOES A POLICYHOLDER WITH AN INDIVIDUAL DISABILITY INSURANCE CONTRACT HAVE A "RIGHT TO RETURN" THE POLICY ONCE IT HAS BEEN ISSUED?

A policyholder may return any individual disability policy within 10 days after receiving it. If the policyholder returns the policy within the 10-day period, the insurance contract is invalid and all payments made under the contract must be refunded.

Persons who purchase a medicare supplement policy, a medicare replacement policy, or a long-term care policy have the right to return the policy or certificate within 30 days of receipt and receive a full premium refund.

The "right to return" must be printed on or attached to the first page of each individual policy.

This "right to return" does not apply to single premium nonrenewable policies issued for terms not greater than six months, or accident-only policies.

[s. 632.73]

EXAMPLE

- A policyholder decided that she did not need a disability insurance policy which she purchased nine days before. The next day, the 10th day, she mailed the individual policy back to the insurance company. Is the policy still valid and is the policyholder obligated to pay premiums which come due?

NO. Under s. 632.73 (1), Wis. Stat., the policyholder has a right to return the policy within 10 days after receiving the policy. Since the policyholder returned the policy by mail within the 10-day period, she complied with the statute. The return of the policy invalidated the contract and the policyholder is not liable for any premiums due under the policy. In addition, any premiums already paid must be refunded to the policyholder by the insurance company.

MAY AN INSURER CONTEST A DISABILITY POLICY ON THE GROUND THAT THE INSURED MADE A MISREPRESENTATION?

Disability policies are incontestable once they have been in force for two years. This means that statements made by an applicant in an application attached to an individual disability insurance policy may not be the basis for voiding a policy, or denying a claim for loss incurred or disability beginning after coverage has been in effect for two years. The contract may provide for a shorter period of contestability. Fraudulent misrepresentation constitutes a valid ground for voiding the policy, regardless of the length of time the policy has been in effect. The policy may provide for incontestability even with respect to fraudulent misstatements.

[s. 632.76(1)]

MAY AN INSURER REFUSE OR REDUCE A CLAIM ON THE GROUND OF A "PREEXISTING CONDITION"?

If a policy has been in effect for at least two years, any claim for loss or disability which occurs after the two-year period may not be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage. The only exception is when the policy contains a provision effective on date of loss which excludes the condition from coverage by name or specific description.

An insurer may not void coverage or deny a claim on the ground that the application did not disclose information material to the risk if the application did not clearly require the disclosure of such information. If an application does not contain any question concerning the applicant's health or medical history, the insurer may use the preexisting condition defense only for those losses incurred within one year after the effective date of coverage. This time limitation is not applicable if the disease or physical condition causing the loss is excluded from coverage by name or specific description effective on the date of loss.

Medicare supplement policies, medicare replacement policies, and long-term care policies may not have a waiting period of more than six months after policy issuance for preexisting conditions for which medical advice was given or treatment was recommended or received within six months prior to the effective date of coverage. If a medicare supplement policy or certificate or a medicare replacement policy or certificate replaces another medicare supplement policy or certificate or another medicare replacement policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting condition waiting periods in the new medicare supplement or medicare replacement policy or certificate for similar benefits to the extent time was satisfied under the original policy or certificate. Refer to the medicare section in this guide for more information on medicare supplement policies.

[s. 632.76(2), ss. Ins 3.28, 3.39(27)]

If a long-term care policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting condition waiting periods, elimination periods and probationary periods in the new long-term care policy or certificate for similar benefits to the extent that similar exclusions were satisfied under the original policy or certificate.

[s. Ins 3.46(14)]

For health insurance plans sold to employers, an insurer may not have a preexisting condition waiting period that extends beyond twelve months, or eighteen months with respect to a late enrollee, after an individual's enrollment date under the plan. An insurer may not define a preexisting condition more restrictively than a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months prior to an individual's enrollment date under the plan. An insurer may not treat genetic information as a preexisting condition without a diagnosis of a condition related to the information, nor can an insurer treat a pregnancy as a preexisting condition.

Insurers providing coverage under a group health benefit plan are also restricted from imposing a preexisting condition exclusion with respect to an individual who is covered under creditable coverage on the last day of the 30-day period beginning with the day on which the individual is born, or with respect to an individual who is adopted or placed for adoption before attaining age 18, and is covered under creditable coverage on the last day of the 30-day period beginning with the day on which the individual is adopted or placed for adoption. Such restrictions do not apply if the individual was not covered under any creditable coverage for at least 63 days.

[632.746(1),(2)]

EXAMPLE

- An application for an individual guaranteed renewable disability policy inquired whether the applicant ever suffered from any lung or breathing ailments. The applicant mistakenly wrote down "no" to the question, although the applicant had been suffering from what he thought was asthma. The policy was issued to the applicant. Having been renewed for three years, the policyholder filed a claim for medical treatment of emphysema. May the insurance company refuse to pay the claim and terminate the policy because of the policyholder's prior material misrepresentation on the application?

No. Under s. 632.76, Wis. Stat., no such statement, unless fraudulent, can be the basis for denying a claim or terminating a policy after coverage has been in effect for more than two years.

WHAT IS PORTABILITY?

An insurer must reduce a preexisting condition waiting period under a group health benefit plan by the aggregate of an employee's or dependent's periods of creditable coverage on the individual's enrollment date under the employer's plan. Creditable coverage means coverage under a group health plan, health benefit plan, medicare, medicaid, a health plan offered under chapter 89 of title 5 or chapter 55 of title 10 of the United States Code, a state health benefits risk pool, a public health plan, a health plan under the federal Peace Corps Act, or a medical care program of the federal Indian health service or of an American Indian tribal organization. Periods of creditable coverage after which the individual was not covered under any creditable coverage for a period of at least 63 days before enrollment in the employer's plan may not be counted. Any waiting period or affiliation period for coverage under the employer's plan may not be counted in determining the period before enrollment in the employer's plan.

An insurer offering a group health benefit plan must count a period of creditable coverage without regard to the specific benefits for which the individual had coverage during the period, unless the insurer elects to reduce the preexisting condition waiting period by the amount of time the individual had prior creditable coverage within each of several classes or categories of benefits. These categories of benefits are limited to prescription drug, dental, vision, mental health, and substance abuse treatment.

This election must be made on a uniform basis for all individuals. Insurers electing the second option must count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category. Insurers must also prominently state in any disclosure statements concerning coverage and to each employer at the time of the offer or sale of coverage, that the insurer has elected the second option and what the effect of that election will be.

[s. 632.746(3)]

HOW DO INDIVIDUALS PROVE THEY HAVE CREDITABLE COVERAGE?

Insurers that provide health benefit plan coverage must provide a written certification of creditable coverage when an individual ceases to be covered under a health benefit plan, when an individual becomes covered under COBRA continuation coverage, and when an individual ceases to be covered under COBRA continuation. Insurers must also provide a certification upon the request of an individual that is made no later than 24 months after the date the individual's coverage ceases, or the date the individual's COBRA continuation begins or ceases, whichever is later. The certification must include information concerning the individual's period of creditable coverage; the coverage, if any, under COBRA; and the waiting period, if any, under the individual's health benefit plan.

[s. 632.746(4)]

WHAT ARE SOME OF THE RESPONSIBILITIES AN INTERMEDIARY OR INSURER HAS REGARDING AN APPLICATION FOR DISABILITY INSURANCE?

If an application form is attached to the policy, it becomes part of the insurance contract. The application can only require that statements made by the applicant are true to the best of the applicant's knowledge and/or belief. The applicant may be required to state that the applicant's answers are true and complete to the best of the applicant's knowledge and/or belief.

An insurance intermediary or representative must review with the applicant all questions contained in each application. The agent or representative must record on each application all material information disclosed by the applicant.

If an insurer issues coverage for a person without having resolved patently conflicting or incomplete statements in the application, or fails to consider information gathered in connection with processing the application, then it cannot use these statements or information to void coverage or deny a claim.

When an application for insurance contains questions relating to the medical history or other matters relating to the insurability of the applicant and will be part of the insurance contract, an insurer must notify the policyholder or certificate holder to check the application for omissions or misstatements which might invalidate a claim. This notice may be printed in contrasting color on the first page of the policy or certificate or in the form of a sticker, letter or other form attached to the first page. The notice may also be furnished in a separate letter or other form that is mailed to the policyholder within 10 days after issuing or amending a policy or contract.

The insurer cannot void coverage or deny a claim on the ground that the application did not disclose certain information considered material to the risk if the application did not clearly require the disclosure of such information.

After coverage for a person has been issued and an insurer receives information regarding that person which would reasonably be considered a sufficient basis to void that person's coverage, the insurer must void the coverage within a reasonable time or else the insurer will be held to have waived its rights to such action.

[s. Ins 3.28]

WHAT GRACE PERIODS ARE REQUIRED IN INDIVIDUAL DISABILITY INSURANCE POLICIES FOR LATE PREMIUM PAYMENTS?

Every disability insurance policy with weekly premiums must contain a provision for a grace period of at least 7 days. Policies with monthly premiums must provide for a grace period of at least 10 days. All other policies require a 31-day grace period. These grace periods apply only to the premiums which follow the initial premium payment. A policy continues in effect during the grace period.

[s. 632.78(1)]

EXAMPLE

- A policyholder of an individual disability insurance policy with an annual premium payment failed to make her payment for the second year's coverage on time. She then mailed in the premium payment two months after the due date. Is the policy still effective?

No. Under s. 632.78 (1), Wis. Stat., such policies have a 31-day "grace period" during which payment can still be made and the policy is still in effect. Since the payment in this case was made after the 31-day period had expired, the insurance company has the discretion whether to reinstate the policy or regard the policy as void.

CAN THE INSURER REFUSE TO PAY FOR SOME PROFESSIONAL HEALTH CARE SERVICES?

Except for covered services provided by chiropractors, nurse practitioners, and optometrists, no insurer may refuse to provide or pay for benefits for health care services because they

were not rendered by a physician if the health care professional holds a license or certificate of registration from the appropriate medical examining board unless the policy provides otherwise.

The insurer may refuse to provide or pay for such benefits only if the insurance contract clearly excludes services by such practitioners.

[s. 632.87]

The law prohibits health insurance policies (other than prepaid plans) from excluding or otherwise limiting coverage for prescription drugs or devices provided by any pharmacist selected by the insured if the pharmacist agrees to abide by the terms of the policy and at the same costs as a pharmaceutical mail order plan.

[s. 632.86]

WHAT ARE THE DISCLOSURE REQUIREMENTS RELATING TO HEALTH CARE CLAIM SETTLEMENTS?

This requirement sets out minimum standards for health insurance policies which provide benefits based on a specific methodology such as "usual, customary, and reasonable" or "prevailing" charges. It applies to HMO plans to the extent such plans make claim settlement determinations for out-of-plan services.

Insurers must include a notice on the first page of the policy or certificate stating that a provider's billing may not be paid in full. The insurer must provide the consumer with a contact person and telephone number.

An insurer, upon an insured's request, must provide a description of the insurer's specific methodology including, but not limited to, the following:

- The source of the data used.
- How frequently the data base is updated.
- The geographic area used in determining the eligible amount.
- If applicable, the percentile used to determine usual, customary, and reasonable charges.
- The conditions and procedures under which a statistical data base on provider charges is supplemented with noncharge data or is otherwise modified.

Insurers are required to disclose, upon request of the insured, the amount allowable under the insurer's guidelines for the determination of the eligible amount of a provider's charges for a specific health care procedure in a given geographical area. The insurer is required to disclose its specific eligible amount only if the provider's charge exceeds the allowable charge under the insurer's guidelines. The insurer's estimate may be in the form of a range of payment or maximum payment.

An insurer is not required to disclose specifically enumerated proprietary information prohibited from disclosure by a contract between the insurer and the source of the data in the data base. If an insured makes a specific and clear request for methodological details not covered in a general disclosure, the insurer must make a reasonable effort to provide a response not requiring the disclosure of proprietary information. Revealing a specific charge level for a procedure or a specific provider name are examples of information that might be construed as proprietary. Methodological details relating to how claims are edited from the data base, how "outliers" or unusual records are treated, the number of claims for any procedure code, or the mix of claims from various sources would be examples of nonproprietary information.

Inquiries and responses may be oral or in writing at the policyholder's or certificate holder's choice. The insurer may require the insured to provide reasonably specific details, including the provider's estimated charge for the procedure(s) and, when necessary to clearly identify the procedure(s), the CPT or CDT code(s), about the health care procedure or service before responding to the insured's request. The insurer shall respond to the request within five working days after the date it receives a sufficiently clear request.

Insurers are required to inform requesters of all of the following:

- Policy benefits are available only to individuals who are eligible for benefits at the time a health care procedure or service is provided.
- Policy provisions including, but not limited to, preexisting condition and contestable clauses and medical necessity requirements, may cause the insurer to deny the claim.
- Policy limitations including, but not limited to copayments and deductibles, may reduce the amount the insurer will pay for a health care procedure or service.
- A policy may contain exclusions from coverage for specified health care procedures or services.

An insurer is not bound by a good faith estimate of allowable charges in its response to a request.

If an insurer pays less than the billed amount of a claim based on its specific methodology, it must furnish the insured or the provider with the medical or dental code it used for determining its allowable charge for the procedure along with the date of the service. In addition, it must furnish a telephone number at the company which may be used to obtain further information, including information on the insurer's specific methodology, on the payment determination.

Insurers must provide information about the reductions along with an explanation of benefits including a telephone number for the policyholder to call to obtain information.

[s. Ins 3.60(6),(7)]

WHAT TYPE OF HEALTH POLICIES MUST DEVELOP AN INTERNAL GRIEVANCE PROCEDURE?

All insurers that issue health benefit plans must develop an internal grievance procedure.
[ss. 632.745(11), 632.83, s. Ins 18.02(1)]

WHAT IS AN INDEPENDENT REVIEW?

The independent review process provides an insured with an opportunity to have medical professionals who have no connection to their health plan review a dispute. The insured chooses the independent review organization (IRO) from a list of review organizations certified by OCI. The IRO assigns the dispute to a clinical peer reviewer who is an expert in the treatment of the disputed medical condition. The IRO has the authority to determine whether the treatment should be covered by the health plan.

[s. 632.835, s. Ins 18.01(6)]

WHAT TYPES OF DISPUTES CAN BE DECIDED THROUGH INDEPENDENT REVIEW?

The dispute must involve a medical judgment. An insured can request an independent review whenever the health plan denies coverage for treatment because it maintains that the treatment is not medically necessary or that it is experimental, including a denial of a request for out-of-network services when the insured believes that the clinical expertise of the out-of-network provider is medically necessary. The treatment must otherwise be a covered benefit under the insurance contract. Also, the total cost of the denied coverage must exceed \$250.

[s. 632.835, s. Ins 18.10]

IS THERE A COST TO THE INSURED?

Yes, the insured must pay a \$25 fee to the IRO. This fee will be refunded if the IRO resolves the dispute in the insured's favor.

[s. 632.835, s. Ins 18.11(2)(a)4]

MUST INSURERS PROVIDE COVERAGE FOR NURSE PRACTITIONERS?

Insurers or self-funded municipalities or self-funded school districts cannot refuse to provide coverage for certain specified tests, examinations, or associated laboratory fees when performed by a nurse practitioner if the policy would provide coverage for the same services when performed by a physician.

[s. 632.87(1),(5)]

MUST INSURERS PROVIDE COVERAGE FOR OPTOMETRISTS?

Insurers may not, under a contract or plan covering vision care services or procedures, refuse to provide coverage for such services provided by an optometrist if the contract or plan includes coverage for the same services or procedures when provided by another health care practitioner.

[s. 632.87(2)]

MUST INSURERS PROVIDE COVERAGE FOR CHIROPRACTIC BENEFITS?

Insurers must include coverage of services by a licensed chiropractor for diagnosis and treatment of a condition or complaint within the scope of the chiropractor's professional license, if the policy covers diagnosis and treatment of the condition or complaint by a licensed physician or osteopath. Insurers are prohibited from:

- Restricting or terminating chiropractic coverage on the basis of an examination or evaluation other than by a chiropractor or peer review panel containing a chiropractor;
- Establishing underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers;
- Refusing to provide coverage to an individual because the individual has been treated by a chiropractor; or
- Excluding or restricting health care coverage of a health condition solely because the condition may be treated by a chiropractor.
- Claims for chiropractic services must be paid within 30 days after the insurer receives clinical documentation from the chiropractor unless, on the basis of an independent evaluation, an insurer restricts or terminates a patient's coverage for treatment.

[s. 632.87]

WHAT STANDARDS APPLY TO COVERAGE OF EMERGENCY MEDICAL SERVICES?

An insurer that provides coverage of any emergency medical services may not deny coverage for emergency services that a reasonably prudent person would consider an emergency, and that are required to evaluate or stabilize the patient. An insurer can also not require prior authorization for emergency services.

[s. 632.85]

WHAT RESTRICTIONS APPLY TO INSURERS WHO ONLY PROVIDE COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND DEVICES?

Insurers that use a formulary or other list of preapproved drugs and devices must have a process to permit a physician to request an individual exception for coverage of a drug or device not normally covered under the plan.

[s. 632.853, s. Ins 3.67 (2)]

WHAT REQUIREMENTS PERTAIN TO COVERAGE FOR EXPERIMENTAL TREATMENT?

Insurers that limit coverage for experimental treatment must disclose such limitations in its policies and certificates, and have a procedure for handling requests for prior authorization of an experimental procedure. Insurers must issue a coverage decision on a request for experimental treatment within five working days of receiving the request. Insurers must also have a procedure to allow an insured to appeal a denial of coverage for an experimental treatment.

[s. 632.855, s. Ins 3.67 (3)]

ARE THERE SPECIAL RIGHTS FOR HANDICAPPED CHILDREN COVERED BY DISABILITY POLICIES?

Hospital or medical expense policies which cover the dependent children of an insured may end coverage when the child reaches the age stated in the contract. However, coverage of a dependent child cannot be ended while the child continues to be both:

- Incapable of self-sustaining employment because of mental retardation or physical handicap; and
- Chiefly dependent upon the person insured under the policy for support and maintenance.

[s. 632.88]

EXAMPLES

- A policyholder purchased a medical expense insurance policy which covered his dependents until they reached the age of 18 years. The policyholder's 8-year-old daughter suffered a bicycle accident which left her right arm and leg partially paralyzed. Her physical handicap prevented her from holding any type of steady employment. She also remained dependent upon her father for support. The insurance company paid all claims which were covered by the policy up to her 18th birthday. May the company now refuse to continue coverage to the daughter?

No. Under s. 632.88, Wis. Stat., the age limitation provision in the policy will not operate to terminate the coverage of a dependent child if the child is both (a) incapable of "self-sustaining" employment due to a physical handicap, and (b) dependent upon the policyholder for support. The company could start charging adult premiums at age 18.

WHAT BENEFITS MUST BE PROVIDED FOR ALCOHOLISM, DRUG ABUSE, AND MENTAL AND NERVOUS DISORDERS?

Group policies which cover inpatient hospital services must provide coverage for such services for the treatment of alcoholism, drug abuse, and nervous and mental disorders. Coverage per policy year must be not less than the lesser of the following: the expenses of

the first 30 days, or \$7,000 of expenses reduced by any applicable cost-sharing (deductibles, copayments, or coinsurance amounts) at the level charged under the policy for other inpatient services, or the equivalent benefit measured in services rendered.

Group policies which cover any outpatient treatment must provide coverage for such treatment of these conditions. Coverage per policy year must be not less than \$2,000 of expenses reduced by any applicable cost-sharing (deductibles, copayments, or coinsurance amounts) at the level charged under the policy for other outpatient services, or the equivalent benefit measured in services rendered.

Group health policies are required to provide coverage for transitional mental health, alcohol, and other drug abuse treatment arrangements, such as day hospitalization. The required amount of coverage is \$3,000 of expenses reduced by any applicable cost-sharing (deductibles, copayments, or coinsurance amounts) at the level charged under the policy for other covered services, or the equivalent benefit measured in services rendered.

[ss. 632.89(2)(b)1,(dm)(4)]

The total coverage for these conditions per policy year need not exceed \$7,000. (The equivalent benefits in services rendered if coverage is provided by a predetermined payment health care plan.)

These coverages may be subject to exclusions or limitations, including deductibles, which are generally applicable to other covered conditions.

These requirements do not apply to individual policies.

[s. 632.89]

HMOs are required to provide certain benefits for outpatient treatment of nervous and mental disorders, alcoholism, and other drug abuse to a dependent student who is attending a school of higher education located in this state but outside the HMO's service area, if the HMO would have provided benefits for such services by a selected provider within the service area.

[ss. 609.05(3),609.655]

WHAT BENEFITS MUST BE PROVIDED FOR HOME CARE?

Every disability insurance policy providing coverage of expenses incurred for inpatient hospital care must provide coverage for no less than 40 home health care visits in any 12-month period for each person covered under the policy. Home health care means the care and treatment of an insured under a plan of care established by the attending physician which may include intermittent home nursing care, home health aide services, various types of therapy, medical supplies and medication prescribed under the home care plan, and nutrition counseling. If an insurer provides disability insurance, or if two or more insurers jointly provide disability insurance, to an insured under two or more policies, home health care coverage is required under only one of the policies.

Insurers may not deny coverage of a home health care claim based solely on medicare's denial of benefits.

Insurers shall disclose and clearly define the home care benefits and limitations in a disability insurance policy, certificate, and outline of coverage.

[s. 632.895, s. Ins 3.54]

WHAT BENEFITS MUST BE PROVIDED FOR SKILLED NURSING CARE?

Policies that cover hospital expenses must provide coverage for at least 30 days for skilled nursing care to patients who enter a licensed skilled nursing care facility. Coverage may be limited to care that is certified as medically necessary by the attending physician. A disability insurance policy other than a medicare supplement or medicare replacement policy may limit coverage to patients who enter a licensed skilled nursing care facility within 24 hours after discharge from a hospital to receive continued care which is for the same condition as treated in the hospital.

[s. 632.895(3)]

WHAT BENEFITS MUST BE PROVIDED FOR KIDNEY DISEASE TREATMENT?

Policies that cover hospital expenses must provide at least \$30,000 of coverage per year for hospital inpatient and outpatient treatment of kidney disease, which may be limited to dialysis, transplantation, and donor-related services. The coverage is not required to duplicate medicare benefits, and may be subject to the same limitations that apply to other covered health conditions.

[s. 632.895(4)]

MUST A DISABILITY INSURANCE POLICY PROVIDE COVERAGE FOR NEWBORN INFANTS?

Every disability insurance policy shall provide coverage for a newly-born child of the insured from the moment of birth. The newborn has the same coverage as the policy provides for any children covered or eligible for coverage under the policy, except that waiting periods do not apply. If a person who is pregnant or whose spouse is pregnant makes application for a policy providing hospital and/or medical expense benefits, the insurer may not issue a policy which excludes or limits benefits for the expected child. The policy must be issued without the exclusion or limitation, or the application must be declined or postponed. Coverage for newly-born children must treat congenital defects and birth abnormalities as an injury or sickness under the policy. The disability policy must cover functional repair or restoration of any body part when necessary to achieve normal body functioning. Coverage is not required for "cosmetic" surgery performed only to improve appearance.

[s. 632.895(5), s. Ins 3.38]

WHAT IF AN ADDITIONAL PREMIUM IS REQUIRED TO PROVIDE COVERAGE FOR A NEWBORN INFANT?

If the payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of a child's birth and payment of the required premiums or fees be furnished to the insurer within 60 days after the date of birth. The

insurer may refuse to continue coverage beyond the 60-day period if such notification is not received, unless within one year after the birth of the child the insured makes all past due payments with interest at the rate of 5 1/2% per annum.

If the payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy or contract may request notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished.

[s. 632.895(5)]

MUST A DISABILITY INSURANCE POLICY PROVIDE COVERAGE FOR ADOPTED CHILDREN?

Yes. Every disability insurance policy that provides coverage for dependent children of the insured must provide coverage for children who are adopted or placed for adoption. This includes health maintenance organizations, preferred provider plans, and limited service health organizations.

[ss. 609.75, 631.07(3)(a)3.m, 632.896]

MUST GRANDCHILDREN BE COVERED?

Every disability insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that provides coverage for a dependent child of the insured must provide the same coverage for children of the dependent child until the dependent child is age 18.

[s. 632.895(5m)]

WHAT BENEFITS MUST BE PROVIDED FOR TREATMENT OF DIABETES?

Every disability policy which provides coverage of expenses incurred for treatment of diabetes shall provide coverage for expenses incurred by the installation and use of an insulin infusion pump and provide coverage for all other equipment and supplies, including insulin, used in the treatment of diabetes. Policies must also provide coverage of diabetic self-management education programs.

Coverage may be subject to the same deductible and coinsurance as other covered expenses. Insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

For policies issued or renewed after January 1, 2003, an insurer must also provide coverage for expenses incurred for prescription medication used in the treatment of diabetes.

[s. 632.895(6)]

MUST MATERNITY BENEFITS BE PROVIDED FOR DEPENDENT CHILDREN?

Every group disability insurance policy which provides maternity coverage shall provide maternity coverage for all persons covered under the policy. If a group policy provides maternity coverage for the insured or insured's spouse, the maternity coverage must also be provided for any dependent children covered under the policy.

[s. 632.895(7)]

WHAT BENEFITS MUST BE PROVIDED FOR MAMMOGRAMS?

Except for specified disease, medicare supplement, medicare replacement, or long-term care policies, every disability policy that provides coverage for a woman age 45 or older, must provide coverage for periodic mammographies. Coverage is required regardless of whether the woman shows any symptoms of breast cancer. The policy may not apply exclusions or limitations that do not apply to other radiological examinations covered under the policy.

[s. 609.80, 632.895(8)]

WHAT BENEFITS MUST BE PROVIDED FOR LEAD POISONING SCREENING?

Except for specified disease, medicare supplement, medicare replacement, or long-term care policies, every disability insurance policy must provide coverage for blood lead tests for children under 6 years of age, which are conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and social services.

[s. 632.895(10)]

WHAT BENEFITS MUST BE PROVIDED FOR TEMPOROMANDIBULAR JOINT DISORDERS?

Except for dental policies and medicare supplement policies, every group or individual disability insurance policy including HMOs, PPPs, and LSHOs and every self-insured health plan of the state or a county, city, village, town or school district, that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle or tissue must provide coverage for diagnostic procedures and medically necessary surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular (TMJ) disorders. Coverage for diagnostic procedures and medically necessary nonsurgical treatment for the correction of TMJ disorders may be limited to \$1,250 annually.

[s. 632.895(11)]

WHAT BENEFITS MUST BE PROVIDED FOR HOSPITAL AND AMBULATORY SURGERY CENTER CHARGES AND ANESTHETICS FOR DENTAL CARE?

Except for dental policies, every group or individual disability insurance policy including HMOs, PPPs, and LSHOs and every self-insured health plan of the state or a county, city,

village, town or school district must cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care if any of the following applies:

1. The individual is a child under the age of 5
2. The individual has a chronic disability that meets all the conditions in s. 230.04(9r)(a)2.a., b., and c., Stat.
3. The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

[s. 632.895(12)]

WHAT BENEFITS MUST BE PROVIDED FOR BREAST RECONSTRUCTION?

Every group or individual disability insurance policy including HMOs, PPPs, and LSHOs and every self-insured health plan of the state or a county, city, village, town or school district, that provides coverage for a mastectomy shall provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

[s. 632.895(13)]

WHAT BENEFITS MUST BE PROVIDED FOR IMMUNIZATIONS FOR CHILDREN?

Effective November 1, 2000, every disability insurance policy and every self-insured health plan of the state or county, city, village, town, or school district that provides coverage for a dependent of an insured, must provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured. The coverage may not be subject to any deductibles, copayments, or coinsurance under the policy or plan.

[s. 632.895(14)]

WHAT SPECIAL PROVISIONS APPLY TO RIDERS AND ENDORSEMENTS OF INDIVIDUAL DISABILITY POLICIES?

A rider is an instrument signed by one or more officers of the insurer which is attached to and forms part of a policy issued by the insurer. If the rider reduces or eliminates coverage of the policy, signed acceptance of the rider by the insured is necessary. However, signed acceptance of the rider is not necessary when the rider is attached at the time of the original issuance of the policy, if proper notice of such rider is contained in contrasting color on the policy's front page and filing back.

An endorsement differs from a rider only in that it is printed or stamped on the policy. If the endorsement reduces or eliminates coverage of the policy, signed acceptance of the endorsement by the insured is necessary. Signed acceptance of the endorsement is not necessary when it is affixed at the time of the original issuance of the policy, if proper notice of such endorsement is contained in contrasting color on the policy's front page and filing back.

[s. 600.03(35)(a), s. Ins 3.13(3)]

WHAT STANDARDS APPLY TO ADVERTISEMENTS FOR DISABILITY INSURANCE?

Prospective buyers of disability insurance must be provided with clear and unambiguous statements, explanations, advertisements, and written proposals concerning policies offered to them.

Section Ins 3.27, Wis. Adm. Code, outlines the minimum standards and guidelines for the advertising and selling of disability policies.

Advertisements and representations must be truthful, and not misleading, and must accurately describe the policy to which they apply.

In addition, the content, form, and method of dissemination of all advertisements, regardless by whom designed, created, written, printed, or used, are the responsibility of the insurer whose policy is advertised. Insurers must require agents to submit all proposed disability advertising to them prior to use.

[s. 628.34, s. Ins 3.27]

Special rules apply to medicare supplement advertisements. Prior to use, an insurer must file a copy of any advertisement used in connection with the sale of its medicare supplement policies with the Commissioner's office. If an intermediary intends to use any medicare supplement advertisement that does not reference a particular issuer or medicare supplement policy, he or she must file the advertisement with the Commissioner's office prior to using it.

[s. Ins 3.39(15)]

WHAT IS AN ADVERTISEMENT?

An advertisement means printed as well as oral representations. This includes:

- Printed and published material, audio visual material, and descriptive material and literature of an insurer used in the media, including the internet and web pages, except for advertisements prepared for the sole purpose of obtaining employees, intermediaries, or agencies;
- Descriptive literature and sales aids of all kinds issued by an insurer or intermediary for presentation to members of the public;
- Prepared sales talks, presentations of material used by intermediaries and representations made by agents in accordance with these talks and presentations, except for materials to be used solely by the insurer for the training and education of its employees or intermediaries.

[s. 628.34, s. Ins 3.27(5)(a)]

WHO IS RESPONSIBLE FOR DETERMINING THE "SUITABILITY" OF A POLICY FOR A PROSPECTIVE BUYER?

Before an intermediary or insurer can advise a prospective buyer to buy an individual policy, the agent or insurer must have reasonable grounds to believe that the recommendation is not unsuitable for the applicant.

The intermediary or insurer must ask such questions as are necessary to determine that the purchase of such insurance is not unsuitable for the prospective buyer.

This section does not apply to an individual policy issued on a group basis.

[s. 628.34, s. Ins 3.27(7)]

WHAT IS AN OUTLINE OF COVERAGE?

An outline of coverage means an appropriately and prominently captioned part of a printed advertisement or separate statement which contains:

- A summary of benefits provided;
- A designation of the type or types of coverage involved;
- Any exceptions, reductions, and limitations which affect the basic provisions of the policy; and
- Any provisions relating to renewability, cancellability, termination, and modification of benefits, losses covered, or premiums because of age or other reasons.

[s. 628.34, s. Ins 3.27(5)(1)]

[See also ss. Ins 3.39 and 3.46 for specific regulations concerning policies sold to the elderly]

WHO IS RESPONSIBLE FOR PROVIDING AN OUTLINE OF COVERAGE TO THE APPLICANT?

Every intermediary must furnish an applicant with an outline of coverage at the time of taking an application for an individual policy.

Every advertisement which constitutes an invitation to apply for a specific individual policy or policies must include an outline of coverage.

The requirement for an outline of coverage does not apply to an advertisement or the taking of an application for an individual policy issued on a group basis or an individual conversion policy issued under a group or franchise insurance plan.

[s. 628.34, s. Ins 3.27(8)]

MUST AN ADVERTISEMENT IDENTIFY THE INSURANCE COMPANY?

The identity of the insurer must be made clear in all of its advertisements. An advertisement may not use a trade name, insurance group designation, name of the parent company of the insurer, name of a government agency or program, name of any other organization, service mark, slogan, or symbol or any device which has the capacity and tendency to mislead or deceive as to the identity of the insurer.

An advertisement may not use any combination of words, symbols, or materials which, by their content, phraseology, shape, color, nature, or other characteristics, is so similar to any materials used by federal, state, or local government agencies that it tends to confuse or mislead prospective buyers into believing that the solicitation is in some manner connected with the government agency.

[s. 628.34, s. Ins 3.27(12)]

WHAT REQUIREMENTS MUST ADVERTISEMENTS MEET REGARDING TESTIMONIALS, ENDORSEMENTS, OR COMMENDATIONS BY THIRD PARTIES?

A testimonial means any statement made by a policyholder, or certificate holder which promotes the insurer and its policy by describing such person's benefits, favorable treatment, or other experience under the policy.

An endorsement means any statement promoting the insurer and its policy made by an individual, group or individuals, society, association, or other organization which makes no reference to the endorser's experience under the policy.

The testimonial or endorsement must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. An advertisement may not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association, or other organization, unless it is a fact. An advertisement may not state or imply that a government publication has commended or recommended the insurer or its policy.

An advertisement may not contain a testimonial, endorsement, or other statement concerning the insurer, its policies, or activities by any person who receives direct or indirect compensation from the insurer in connection with the testimonial, endorsement, or statement, unless the advertisement discloses that the person giving the testimonial or endorsement is being paid. The rules of this paragraph do not apply if the person making the testimonial, endorsement, or statement holds a Wisconsin insurance intermediary license, or if the person is a radio or television announcer that is employed or compensated on a salaried or union wage scale basis.

[s. 628.34, ss. Ins 3.27(5),(13)]

ARE ADVERTISEMENTS ALLOWED TO CONTAIN DISPARAGING COMPARISONS AND STATEMENTS?

An advertisement may not directly or indirectly make unfair or incomplete comparisons of policies or benefits. An advertisement may not falsely or unfairly disparage, discredit, or criticize competitors, their policies, services, or business methods or competing marketing methods.

[s. 628.34, s. Ins 3.27(23)]

WHAT IS THE METHOD OF DISCLOSURE OF REQUIRED INFORMATION?

All information required to be disclosed to the prospective buyer by s. Ins 3.27, Wis. Adm. Code, must be set out clearly, conspicuously, and in close proximity to the statements to which such information relates. Required information can also be set out under appropriate captions of such prominence that it is readily noticed and not minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

[s. 628.34, s. Ins 3.27(24)]

WHAT OTHER STANDARDS MUST BE MET WHEN AN ADVERTISEMENT CONTAINS STATEMENTS ABOUT AN INSURER?

An advertisement may not contain statements which are untrue or are by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age, experience, or relative position in the insurance business.

[s. 628.34, s. Ins 3.27(22)]

ARE THERE CERTAIN WORDS AND PHRASES THAT SHOULD NOT BE USED IN ADVERTISEMENTS?

The words and phrases "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills," "this policy will fill the gaps under medicare and your present insurance," or "this policy will replace your income," or similar words and phrases may not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used only in such manner as to fairly describe a benefit.

An advertisement may not state that the insurer "pays hospital, surgical, medical bills," "pays dollars to offset the cost of medical care," "safeguards your standard of living," "pays full coverage," "pays complete coverage," "pays for financial needs," "provides for replacement of your lost paycheck," "guarantees your paycheck," "guarantees your income," "continues your income," "provides a guaranteed paycheck," "provides a guaranteed income," or "fills the gaps in medicare" or use similar words or phrases unless the statement is literally true. Where appropriate, these or similar words or phrases may properly be used if preceded by the words "help," "aid," "assist," or similar words.

An advertisement may not contain the expressions "extra cash," "cash income," "income," "cash," or similar words or phrases in such a way as to imply that the insured will receive benefits in excess of his or her expenses while being sick, injured, or hospitalized.

[s. 628.34, s. Ins 3.27(9)]

WHAT IS REPLACEMENT OF DISABILITY INSURANCE?

Wisconsin law seeks to safeguard the interests of persons covered under disability insurance policies who consider the replacement of their insurance by giving them information regarding replacement. Such information reduces the possibility of misrepresentation and other unfair practices and methods of competition in the business of insurance.

This section on replacement applies to most disability policies issued in Wisconsin. (There are some exceptions listed in s. Ins 3.29, Wis. Adm. Code.)

Replacement is any transaction in which new disability insurance is to be purchased, and it is known to the intermediary or company at the time of application that existing disability insurance has been or is to be lapsed or the benefits substantially reduced.

An application for insurance must contain a question as to whether the insurance to be issued is to replace any insurance presently in force. A supplementary application or other form signed by the applicant may be used for this purpose.

If the sale involves replacement, an intermediary must give the applicant the proper notice, as defined in the next section, and leave a copy of this notice with applicant. A signed copy of this notice must be kept by the insurer.

[s. 628.34, s. Ins 3.29]

WHAT NOTICE IS NECESSARY WHEN A DISABILITY POLICY IS REPLACED?

Proper notice requires that certain facts regarding replacement must be pointed out to the applicant. Proper notice includes written warnings that:

- Health conditions which the applicant might already have may not be covered under a new policy;
- Even if existing health conditions of the applicant are covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective;
- Questions in the application must be answered truthfully and completely, otherwise the validity of the policy and the payment of any benefits under the new policy may be voided;
- The new policy will be issued at a higher age than was the applicant's present policy, and the cost of the new policy, depending upon benefits, may be higher than the applicant is presently paying;

- The renewal provisions of the new policy should be reviewed by the applicant;
- It may be advantageous for the applicant to secure the advice of his or her present insurer or intermediary regarding replacement of the applicant's present policy.

[s. 628.34, s. Ins 3.29]

The notice required when a medicare supplement policy is being replaced must also contain an introductory statement regarding the right to return the new policy under s. 632.73, Wis. Stat., for a refund.

WHAT IS MEDICARE?

Medicare is the federal health insurance program administered by the Social Security Administration for those who are 65 years of age or over, and for some persons under 65 who are disabled. Medicare has two components: hospital insurance (Part A), and medical insurance (Part B).

Under the hospital plan (Part A), hospital inpatient coverage (which includes semi-private room and board, general nursing, and miscellaneous hospital services) medicare provides 60 days of hospitalization after an initial deductible per benefit period. It provides partial coverage from the 61st to the 150th day per calendar year. After the 150th day, it provides no coverage.

Medicare provides limited benefits for up to 100 days of post-hospital care in a facility approved by medicare. It pays all costs for the first 20 days. Medicare recipients pay a portion of the costs for the 21st to the 100th day. After that, medicare coverage for skilled nursing care stops.

Under the medical coverage (Part B), physician's fees, outpatient hospital services, surgeon's fees, inpatient medical services, home health care, and other eligible outpatient services and supplies are covered. The recipient pays an annual deductible and 20% of the medicare-approved charges, with medicare covering the remaining 80% of the medicare-approved charges. Medicare determines what dollar amount is the maximum allowable charge for a particular service and pays the recipient on the basis of this amount.

Medicare does not pay for prescription drugs which are self-administered or over-the-counter drugs. Hearing aids, routine medical check-ups and confinement for custodial reasons are similarly excluded. Coverage for psychiatric care is subject to limitations.

Detailed information about medicare is provided in "Your Medicare Handbook" published by the Social Security Administration.

WHAT ABOUT INSURANCE PLANS WHICH "SUPPLEMENT" MEDICARE?

Some insurers offer a health insurance plan to fill the "gaps" in medicare such as the deductibles and coinsurance payments under Parts A and B of medicare. No private insurance policy will cover everything which medicare will not. For example, supplemental

policies usually cover only "reasonable and necessary" charges or services as defined by medicare. It is unlawful to claim that a medicare supplement policy "fills the medicare gap" or "pays everything medicare does not" because none do so entirely. Section Ins 3.27, Wis. Adm. Code, prescribes advertising standards applicable to medicare supplements and requires fair representations of both the private insurance being sold and the medicare program. This includes a prohibition against an intermediary describing himself or herself as connected in any way with the medicare program.

Not everyone needs individual medicare supplement coverage. Some retired persons are eligible to "convert" from their individual or group health coverage or retain previous coverage with changed benefits. Persons with comprehensive group coverage do not need to purchase individual policies. Persons on Title 19—the federal Medical Assistance program, also known as Medicaid—should not purchase a supplemental policy because this program covers most health care expenses. (If you have medigap insurance and later become eligible for Medicaid, you can request that benefits and premiums be suspended for up to two years while you are covered by Medicaid.)

Section Ins 3.39, Wis. Adm. Code, took effect January 1, 1978, and was substantially amended in 1982, 1986, 1989, 1990, and 1991. Insurers may sell only one individual medicare supplement insurance policy form in the state with up to six additional standardized benefit riders provided for in the rule. Insurers may not sell medicare supplement coverage with benefits other than those contained in s. Ins 3.39, Wis. Adm. Code. Every individual policy which is sold as a supplement to medicare or as a medicare risk contract must be appropriately labeled. Individual policies which do not qualify may not be sold or described as medicare supplements. In particular, separate long-term care policies, hospital confinement indemnity policies, and specified disease policies may not be described as "medicare supplements."

Medicare and Choice insurance is a special arrangement between the federal Health Care Financing Administration (HCFA) and certain HMOs. Under these arrangements, the federal government pays the HMO a set amount for each medicare enrollee. The HMO agrees to provide all medicare benefits. The HMO will also provide some additional benefits which may be at an additional cost.

All medicare supplement and medicare replacement insurance policies must contain a provision allowing for midterm cancellation at the request of the insured, and providing for a prorated premium refund if the policyholder cancels a policy midterm. Insurers must also provide a prorated premium refund to the insured's estate if the insured dies during the term of the policy.

Medicare select, which may be offered by insurance companies and HMOs, is the same as standard medigap insurance in nearly all respects. The only difference between medicare select and standard medigap insurance is that medicare select policies will only pay full supplemental benefits if covered services are obtained through specified health care professionals. The specified health care professionals, often called "plan providers," are selected by the insurance company or HMO. Each issuer of a medicare select policy makes arrangements with its own network of plan providers.

Medicare supplements, medicare select, medicare replacements, and long-term care policies must include an appeal procedure to respond to denied claims.

Section Ins 3.39, Wis. Adm. Code, places a responsibility on insurance companies and intermediaries to deliver a copy of the pamphlet "Wisconsin Guide for Health Insurance for People with Medicare" with every solicitation for a policy covered by this rule whether or not an application is actually completed. The pamphlet is also available from the Commissioner's office. Outlines of coverage and replacement notices must be provided in the appropriate situations [see ss. Ins 3.27 (8) and 3.29, Wis. Adm. Code]. An intermediary who sells disability insurance to a person with the knowledge that the person receives medical assistance, or fails to inquire about receipt of medical assistance, may violate the requirements of s. Ins 3.27 (7), Wis. Adm. Code, regarding suitability.

Section Ins 3.39, Wis. Adm. Code, does not invalidate medicare supplement policies bought before it took effect. Intermediaries should not replace existing coverage simply because it "isn't up to date," but should only recommend a new policy if the existing policy is clearly inadequate for that policyholder's insurance needs.

An insured under individual, family, or group hospital or medical coverage who will become eligible for medicare and is offered a conversion policy must be furnished by the insurer, at the time the conversion application is furnished in the case of individual or family coverage, or within 14 days of request in the case of group coverage, an appropriate outline of coverage and a copy of the pamphlet. Upon request, an insurer must provide a comprehensive written explanation of benefits and the pamphlet to each insured soon to be medicare eligible whose coverage under an individual, family, or group insurance policy will continue with changed benefits. Such changed benefits may take the form of medicare carve-out coverage.

[ss. 628.34, 632.84, ss. Ins 3.27,3.39]

ARE THERE SPECIAL REGULATIONS CONCERNING LONG-TERM CARE INSURANCE?

There are three types of health insurance policies that can be approved:

- A long-term care policy which provides institutional and community-based benefits;
- A nursing home policy which provides institutional benefits; and
- A home health care policy which provides community-based benefits.

The rule designates a specific caption for each type of policy. It also covers life insurance long-term care coverage which is included in a life insurance policy or an endorsement or rider to a life insurance policy.

Insurers and intermediaries must provide an outline of coverage and the guide to long-term care to all prospective purchasers of long-term care insurance.

The rule requires an anticipated loss ratio of at least 65% for individual policies, 65% for group policies issued through the mail, and 75% for other group policies.

Insurers are required to provide a prorated premium refund if the policyholder requests cancellation. Insurers must also provide a prorated premium refund to the insured's estate if the insured dies during the term of the policy. A provision describing these midterm cancellation rights must be included in all long-term care insurance policies.

[s. 632.825, s. Ins 3.46]

WHAT ARE THE CONTINUATION/CONVERSION PRIVILEGES OF INSUREDS UNDER GROUP AND INDIVIDUAL HEALTH INSURANCE POLICIES?

Wisconsin has a continuation/conversion law for both group and individual health insurance policies.

The major provisions are:

- Insurers must permit people who have been insured for at least three months under a group contract to continue group coverage or convert to an individual contract if the group coverage ends because of divorce, annulment, death or any other reason except discharge for misconduct.
- The rate for continued group coverage can't be more than the group rate (including the employer's contribution).
- Employers must continue to accept premiums from these insureds.
- After 18 months, insurers can require those who elect continuation to switch to an individual conversion policy which has been approved by the Office of the Commissioner of Insurance.
- Insurers or group policyholders must notify insureds of their continuation/conversion options when their group coverage terminates.
- Individual policies under which coverage for dependent spouses and children is terminated after a divorce or annulment must provide a conversion option.

There is also a federal law relating to continuation. This law (COBRA) applies to most employers with 20 or more employees. There are some differences between the state and federal law. The federal Department of Labor enforces this law.

[s. 632.897, ss. 3.41, 3.42, 3.43, 3.44, 3.45]

WHAT IS A SMALL EMPLOYER?

A small employer means an individual, firm, corporation, partnership, limited liability company, or association that is actively engaged in a business enterprise in Wisconsin, including a farm business, and that employs an average of at least 2 but not more than 50 employees on business days during the preceding calendar year, or that is reasonably expected to employ at least 2 but not more than 50 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar

year and employs at least 2 employees on the first day of the plan year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

[s. 635.02(7)]

WHAT IS A SMALL EMPLOYER UNIFORM EMPLOYEE APPLICATION?

Effective August 1, 2003, every small employer insurer is required to use the uniform employee application form developed by the OCI, when a small employer applies for coverage under a group health benefit plan offered by the small employer insurer. The intent of the legislation is to reduce the number of forms employees are required to complete when a small employer applies for group health insurance. It also permits small employers to seek premium information from different small employer insurers with one form. Having a uniform employee application that could be used to obtain multiple premiums also has the benefit of decreasing the amount of time spent by the small employer in obtaining the premium information since the form may be photocopied and submitted simultaneously to several insurers.

[s. Ins 8.49]

ARE THERE SPECIAL PROVISIONS RELATING TO THE SALE OF GROUP OR INDIVIDUAL HEALTH INSURANCE POLICIES TO SMALL EMPLOYERS?

Yes. The law:

- Applies to all group plans that provide health insurance coverage to small employers and to individual health insurance policies, when 3 or more eligible employees are provided coverage through individual policies which are sold through the active cooperation of the small employer such as situations where the employer contributes toward or collects the premium for the individual health plans. Also applies to coverage through a trust or association policy if coverage is provided to a small employer;
- Requires small employer insurers that offer group health benefit plans in the small group market to accept any small employer in the state that applies for such coverage, and to accept any eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health benefit plan.
- Prohibits insurers from charging rates that deviate more than plus or minus 30% from the average rate charged for all groups with similar case characteristics and similar benefit design characteristics;
- Prohibits insurers from increasing rates more than 15% yearly due to claim experience;

- Requires insurers to maintain complete and detailed records relating to its rating and renewal underwriting methods and practices, and to annually file information relating to its small employer plans with OCI.

[ch. 635, ch. Ins 8]

ARE THERE EXCEPTIONS TO THE REQUIREMENT THAT SMALL EMPLOYER INSURERS ACCEPT ANY SMALL EMPLOYER THAT APPLIES FOR COVERAGE?

Yes. Small employer insurers may establish minimum participation and employer contribution rules and requirements for the offering of a group health benefit plan in the small group market.

A small employer insurer that offers a group health benefit plan in the small group market through a network plan may limit the small employers that may apply for such coverage to those with eligible individuals who reside, live or work in the service area of the network plan.

A small employer insurer may also deny small employers coverage if it can demonstrate to OCI that it either does not have the capacity to deliver services adequately to additional groups (network plans) or does not have the financial reserves necessary to underwrite additional coverage. A small employer insurer that denies coverage in such instances may not offer coverage in the small group market for 180 days or until the insurer demonstrates to OCI that it has sufficient financial reserves to underwrite additional coverage, whichever is later.

A small employer insurer is not required to accept any small employer in the state that applies for such coverage if the insurer's group health benefit plan is offered in the small group market only through one or more bona fide associations and certain conditions are met.

[s. 635.19]

WHAT ARE THE SOLICITATION AND DISCLOSURE REQUIREMENTS FOR THE SALE OF GROUP OR INDIVIDUAL HEALTH INSURANCE POLICIES TO SMALL EMPLOYERS?

Before completing an application for a policy, an agent is required to provide the small employer with a form providing the following information:

- The insurer's right to increase premium rates and the factors limiting the amount of the increase.
- The extent to which benefit design characteristics affect premium rates.
- The extent to which rating factors and changes in benefit design characteristics and case characteristics affect changes in premium rates.
- The small employer's renewability rights.

- The small employer's right to ask for information concerning the policy's preexisting condition exclusions, and the benefits and premiums under all other health insurance coverage that the insurer offers, for which the small employer is qualified.

The agent is required to sign and date the form certifying that the above information was made available to the small employer prior to completing the application and obtain the signature of the small employer acknowledging receipt of the information. The agent must give one copy of the form to the small employer and the agent or the insurer shall retain one copy of the completed form.

[s. 635.11, s. Ins 8.48]

WHAT ARE THE FAIR MARKETING STANDARDS FOR SMALL EMPLOYER HEALTH INSURANCE PLANS?

Small employer insurers must actively market health benefit plan coverage to small employers in the state.

Insurers may not discourage a small employer from applying for coverage or encourage the small employer to seek coverage from another insurer because of health status, claims experience, industry, occupation, or geographic location of the small employer. Insurers and intermediaries may provide information about established service areas or restricted network provisions of the small employer insurer.

Insurers may not enter into a contract with an agent which provides for or results in compensation that varies according to the health status, claims experience, industry, occupation, or geographic location of the small employer or its employees.

Insurers may not terminate or limit a contract entered into or renewed with an agent based on the health status, claims experience, industry, occupation, or geographic location of the small employers or their employees placed by the agent with the insurer.

Insurers or agents may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage.

If an insurer denies an application for coverage of a small employer, it must deny the application in writing and state the reasons for denial.

Insurers are prohibited from requiring a small employer to purchase or qualify for any other insurance product or service, or purchase or qualify for a health benefit plan which includes coverage other than health insurance, as a condition to the offer or sale of a health benefit plan to a small employer.

A small employer insurer must establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health benefit plans and how to apply for coverage. The toll-free line does not have to be dedicated for this purpose.

[s. 635.18, s. Ins 8.68]

WHAT ARE THE MINIMUM PARTICIPATION AND CONTRIBUTION REQUIREMENTS THAT CAN BE USED BY AN INSURER IN DETERMINING WHETHER TO PROVIDE COVERAGE UNDER A GROUP HEALTH BENEFIT PLAN TO AN EMPLOYER?

Insurers must apply minimum participation and employer contribution requirements uniformly among all employers. They may vary minimum participation and contribution requirements only by the size of each employer group.

Insurers may increase the minimum participation or employer contribution requirements once per calendar year only if the requirements are applied uniformly to all employers applying for coverage and to all renewing employers effective on the date of renewal.

Insurers may establish separate participation or employer contribution requirements that uniformly apply to all employers that provide a choice of coverage to employees or their dependents unless limited by rule. Insurers may also establish separate uniform requirements based on the number or type of choice of coverage provided by the employer.

Except as allowed above, an insurer may vary the requirements used in determining whether to provide coverage to a large employer, but only if the requirements are applied uniformly among all large employers that have the same number of eligible employees.

In applying minimum participation requirements, an insurer may not count eligible employees who have other creditable coverage, except when the creditable coverage is provided under another health benefit plan that is sponsored by that employer.

[s. 632.746(9)]

ARE THERE PROHIBITED COVERAGE PRACTICES RELATING TO EMPLOYER GROUP HEALTH BENEFIT PLANS?

Yes. Except as may be permitted by rule, an insurer that offers a group health benefit plan to an employer, must offer coverage to all of the employer's eligible employees and their dependents. Insurers may not offer coverage to only certain individuals in the group or to only part of the group, except for an eligible employee who has not yet satisfied a waiting period, if any.

An eligible employee means an employee who works on a permanent basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership and a member of a limited liability company if such a person is included as an employee under a health benefit plan of an employer. The term does not include an employee who works on a temporary or substitute basis.

An insurer may not modify an employer's coverage or the coverage of an eligible employee or dependent, through the use of riders or endorsements, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the group health benefit plan.

Unless otherwise permitted by rule, an insurer that provides coverage under a group health benefit plan must provide coverage to eligible employees and their dependents who become eligible for coverage after the commencement of the employer's coverage, regardless of their health conditions or claims experience, if the employee has satisfied any applicable waiting period and the employer agrees to pay the premium required for coverage of the employee under the plan.

An insurer may not establish rules for the eligibility of any individual to enroll or remain enrolled under a group health benefit plan that are based on any of the following factors:

1. Health status
2. Medical condition, including both physical and mental illnesses
3. Claims experience
4. Receipt of health care
5. Medical history
6. Genetic information
7. Evidence of insurability, including conditions arising out of acts of domestic violence
8. Disability

Rules for eligibility to enroll under a group health benefit plan include rules defining any applicable waiting periods for enrollment.

An insurer may not require an individual to pay, on the basis of any health status-related factor, a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled under the plan.

[ss. 632.746(10), 632.747, 632.748]

MUST INSURERS OFFER COVERAGE TO LATE ENROLLEES?

Yes. Insurers offering a group health benefit plan must permit an employee, or a participant's or employee's dependent, who is not enrolled but who is eligible for coverage, to enroll for coverage if all the following apply:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.
2. The employee or dependent stated in writing at the time coverage was previously offered that having other coverage was the reason the individual was declining coverage under the insurer's group health benefit plan. This applies only if the insurer required such a statement and provided the employee with notice of the requirement and the consequences of the requirement at the time coverage was previously offered.
3. The employee or dependent is currently covered under the other coverage, or the employee or participant requests enrollment under the group health benefit plan no later than 30 days after the date on which the other coverage is exhausted or terminated.

[s. 632.746(6)]

MUST INSURERS OFFER SPECIAL ENROLLMENT PERIODS?

Yes. An insurer offering a group health benefit plan, shall provide for a special enrollment period during which:

1. A person who marries an individual and who is otherwise eligible for coverage may be enrolled under the plan as a dependent of the individual.
2. A person who is born to, adopted by or placed for adoption with an individual may be enrolled under the plan as a dependent of the individual.
3. A person who has met any waiting period under the plan, who is eligible to be enrolled under the plan, and who failed to enroll during a previous enrollment period, or the individual's spouse, or both, may be enrolled under the plan,

if all of the following apply:

- a. The group health benefit plan makes coverage available for dependents of participants under the plan.
- b. The individual is a participant under the plan, or the individual has met any waiting period under the plan, and is eligible to enroll under the plan, but failed to enroll during a previous enrollment period.
- c. A person becomes a dependent of the individual through marriage, birth, adoption or placement for adoption.

The special enrollment period shall be not less than 30 days and shall begin on the date dependent coverage is made available under the group health benefit plan, or the date of the marriage, birth, adoption, or placement for adoption, whichever is later.

If an individual enrolls a dependent during a special enrollment period, coverage for a person who becomes a dependent through marriage shall become effective no later than the first day of the first month beginning after the date on which the completed request for enrollment is received. Coverage for a person who becomes a dependent through birth shall become effective the date of birth. Coverage for a person who becomes a dependent through adoption or placement for adoption shall become effective on the date of adoption or placement for adoption.

[s. 632.746(7)]

MAY A HEALTH MAINTENANCE ORGANIZATION IMPOSE AN AFFILIATION PERIOD BEFORE COVERAGE IS EFFECTIVE?

An HMO that offers a group health benefit plan without a preexisting condition exclusion may impose an affiliation period only if the affiliation period is applied uniformly without regard to any health status-related factors, and does not exceed 2 months, or 3 months with respect to a late enrollee. An affiliation period shall begin on the enrollment date and

run concurrently with any waiting period under the health benefit plan. An HMO that imposes an affiliation period is not required to provide health care benefits during the period. If benefits are provided during the affiliation period, an HMO may not charge a premium for the coverage.

[s. 632.746(8)]

ARE THERE SPECIAL REGULATIONS REGARDING THE TERMINATION OR NONRENEWAL OF EMPLOYER GROUP HEALTH BENEFIT PLANS?

Yes. Except as otherwise permitted below, an insurer that offers a group health benefit plan must renew such coverage or continue such coverage in force at the option of the employer and, if applicable, plan sponsor. An insurer may modify a group health benefit plan issued in the large group market at the time of renewal.

An insurer may nonrenew or discontinue a group health benefit plan only for the following reasons:

- Nonpayment of premium
- Fraud
- Failure to meet minimum participation or employer contribution requirements
- The insurer ceases to offer coverage in the market in which the group health benefit plan is included.
- In the case of network plans, there is no longer an enrollee under the plan who resides, lives or works in the service area.
- In the case where coverage is provided through a bona fide association, the employer ceases to be a member of the association on which the coverage is based. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.

An insurer may discontinue offering a particular type of group health benefit plan in either the small or large group market if all the following apply:

1. The insurer provides notice of the discontinuance to each employer and plan sponsor, and to the participants and beneficiaries who have such coverage at least 90 days before the date coverage will be discontinued.
2. The insurer offers to each employer or plan sponsor the option to purchase from among all of the other group health benefit plans that the insurer offers in the market in which the discontinued plan is included. However, in the large group market, the insurer must offer each employer or plan sponsor the option to purchase one other group health benefit plan that the insurer offers in the large group market.
3. The insurer must act uniformly without regard to any health status-related factor of any covered participants or beneficiaries who may become eligible for coverage.

An insurer may discontinue offering in this state all group health benefit plans in the large or small group market, or in both, only if all the following apply:

1. The insurer provides notice of the discontinuance to the commissioner, to each employer and plan sponsor, and to the participants and beneficiaries who have such coverage in this state at least 180 days before the date coverage will be discontinued.
2. All group health benefit plans issued or delivered for issuance in this state in the affected market are discontinued and coverage under such plans is not renewed.
3. The insurer does not issue or deliver for issuance in this state any group health benefit plan in the affected market before 5 years after the day on which the last group health benefit plan is discontinued.

[s. 632.749]

ARE THERE SPECIAL REGULATIONS REGARDING THE TERMINATION OR NONRENEWAL OF INDIVIDUAL HEALTH BENEFIT PLANS?

Yes. Except as otherwise permitted below, an insurer that provides individual health benefit plan coverage must renew such coverage or continue such coverage in force at the option of the insured individual and, if applicable, the association through which the individual has coverage. An insurer may modify an individual health benefit plan coverage policy form at the time of renewal, as long as the modification is consistent with state law and effective on a uniform basis among all individuals with coverage under that policy form.

An insurer may nonrenew or discontinue the individual health benefit plan coverage of an individual only for the following reasons:

- Nonpayment of premium
- Fraud
- The insurer ceases to offer individual health benefit plan coverage.
- In the case of network plans, the individual no longer resides, lives or works in service area. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.
- In the case where coverage is provided through a bona fide association, the individual ceases to be a member of the association on which the coverage is based. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.
- The individual is eligible for Medicare and the commissioner by rule permits coverage to be terminated.

An insurer may discontinue offering a particular type of individual health benefit plan coverage in this state if all the following apply:

1. The insurer provides notice of the discontinuance to each individual for whom the insurer provides coverage of this type, and if applicable, the association through which the individual has coverage at least 90 days before the date coverage will be discontinued.

2. The insurer offers to each individual for whom the insurer provides coverage of this type, and if applicable, the association through which the individual has coverage the option to purchase any other type of individual health insurance coverage that the insurer offers for individuals.
3. The insurer must act uniformly without regard to any health status-related factor of individuals who may become eligible for coverage.

An insurer may discontinue offering in this state individual health benefit plan coverage only if all the following apply:

1. The insurer provides notice of the discontinuance to the commissioner, and to each individual for whom the insurer provides individual health benefit plan coverage in this state and, if applicable, to the association through which the individual has coverage at least 180 days before the date coverage will be discontinued.
2. All individual health benefit plan coverage issued or delivered for issuance in this state is discontinued and coverage under such plans is not renewed.
3. The insurer does not issue or deliver for issuance in this state any individual health benefit plan coverage before 5 years after the day on which the last individual health benefit plan coverage is discontinued.

An insurer is not required to renew individual health benefit plan coverage that is marketed and designed to provide short-term coverage as a bridge between coverages.

[s. 632.7495]

WHAT CONSTITUTES UNFAIR DISCRIMINATION IN DISABILITY INSURANCE?

It is unfair discrimination and an unfair marketing practice for insurers to refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual or charge a different rate for the same coverage solely because of physical or mental impairment except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

It is unfair discrimination to refuse to insure, refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

An insurer may not use sexual orientation in the underwriting process or in the determination of insurability, premium, terms of coverage, or nonrenewal.

[s. 628.34, s. Ins 6.67]

WHAT ARE THE SPECIAL DISCLOSURE REQUIREMENTS FOR THE SALE OF CANCER INSURANCE?

Insurers and intermediaries who sell cancer insurance must give each prospective buyer a copy of "A Shopper's Guide to Cancer Insurance" found in s. Ins 3.47, Wis. Adm. Code, at the time the prospect is contacted with an invitation to apply.

This rule does not apply to solicitations in which the booklet, "Wisconsin Guide for Health Insurance for People with Medicare," is given to applicants as required by s. Ins 3.39, Wis. Adm. Code.

[s. 628.34, s. Ins 3.47]

ARE THERE ANY SPECIAL REQUIREMENTS RELATING TO AIDS?

Under current Wisconsin law insurers writing individual accident and health insurance in Wisconsin may require applicants for insurance to be tested for the presence of the antibody to HTLV-III and disclose whether they have obtained a test or the results of such test. Applicants for group accident and health insurance may not be required to take a test or disclose whether they have obtained a test or the results of such test. Insurers may only test for the presence of the antibody to HTLV-III, using FDA-licensed tests or ask for the results of FDA-licensed tests.

Insurers may only disclose the results of the test to:

- The applicant or insured who is tested.
- The applicant's or insured's health care provider if the applicant or insured provides the insurer with informed consent for testing or disclosure.
- Such other person as the applicant or insured authorizes through an informed consent for testing or disclosure.

Insurers may disclose the results of the prescribed series of tests to the Medical Information Bureau, Inc., only after receiving the informed consent from the applicant who undergoes the test.

An insurer may not require or request any individual to reveal whether the individual has undergone a test at an anonymous counseling and testing site, or through the use of a home test kit.

[s. 631.90, s. Ins 3.53]

Any person who has tested positive for the presence of HIV or an antibody in HIV is automatically eligible for coverage under the Health Insurance Risk Sharing Plan (HIRSP).

[s. 149.12(1)]

An accident and health insurance policy is prohibited from containing any exclusions or limitations for coverage of the treatment of HIV infection or any affiliated condition unless the same exclusions or limitations apply to all other conditions.

[s. 631.93]

All disability policies except specified disease, limited service health organization, medicare replacement, and medicare supplement policies that provide coverage for prescription medications are required to provide coverage for FDA-approved drugs including phase 3 clinical investigational drugs for the treatment of HIV infection or related illnesses.

[s. 632.895(9)]

ARE THERE SPECIAL REGULATIONS FOR MANAGED CARE PLANS?

Yes. A managed care plan is defined as any health benefit plan that requires or creates incentives for an enrollee to use providers that are owned, managed, or under contract with the insurer offering the health benefit plan.

Wisconsin statutes define three different types of managed care plans. They are health maintenance organizations, preferred provider plans, and limited service health organizations.

A "health maintenance organization" is a health care plan that makes available to enrolled participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

A "limited service health organization" is a health care plan that makes available to enrolled participants, in consideration for predetermined periodic fixed payments, a limited range of health care services performed by providers selected by the organization.

A "preferred provider plan" is a health care plan that makes available to its enrolled participants for consideration other than predetermined periodic fixed payments, either comprehensive health care services or a limited range of health care services performed by providers selected by the organization.

Except for an employer with fewer than 25 full-time employees, an employer that offers any of its employees a health maintenance organization or a comprehensive preferred provider plan must also offer employees a standard plan.

Employers must give employees an annual opportunity to enroll in the plans provided. Employers must also give employees adequate notice of the opportunity to enroll in the health care plans and complete and understandable information concerning the differences between the plans offered.

All health maintenance organizations, limited service health organizations, and preferred provider plans must establish internal grievance procedures.

[ch. 609, ch. Ins 9]

WHAT ARE PROHIBITED INSURANCE PRACTICES INVOLVING DOMESTIC ABUSE?

Effective November 1, 2000, insurers are prohibited from:

- Refusing to provide or renew or from cancelling a person's coverage under an individual or group policy or certificate on the basis that the person or a member of the person's family has been or is a victim of domestic abuse;
- Refusing to provide or renew or from cancelling an employer's or other group's coverage on the basis that an employee or other group member or a member of their family has been or is a victim of domestic abuse;
- Rating an individual or group policy on knowledge or suspicion that a person has been or is a victim of domestic abuse.

Insurers writing individual or group disability insurance also may not exclude or limit coverage of, or deny a claim for health care services related to the treatment of injury or disease resulting from domestic abuse on the basis that the person has been or is a victim of domestic abuse.

[s. 631.95]

ARE THERE SPECIAL REGULATIONS FOR MULTIPLE EMPLOYER TRUSTS?

Yes. State law requires a multiple employer trust or association, or agent, to file an informational report with OCI before soliciting Wisconsin residents if:

- It is defined as a multiple employer welfare arrangement under federal law;
- It is, or purports to be, subject to the Federal Employee Retirement Income Security Act (ERISA) and exempt from state insurance regulation; or
- It is established outside this state and is not domiciled in the U.S.

The filing must include a copy of any insurance policy or contract covering benefits offered by the organization, a copy of the trust or association's organizational documents, and a statement that the benefits are fully insured or a description of the extent to which they are not fully insured. The organization must update the filing within 15 days of any change or whenever the information previously provided is no longer accurate.

A multiple employer trust or association that provides coverage subject to a collective bargaining agreement, that is fully insured by a Wisconsin-licensed insurer, that provides coverage to a governmental unit, that is an individual, or that is exempted by the Commissioner is not subject to this rule.

[s. Ins 6.62]

CHAPTER V

LIFE INSURANCE AND ANNUITIES

The basic purpose of life insurance is the financial protection of the insured's beneficiaries/dependents if the insured should die. Upon death of the insured, the insurer is legally obligated to pay a previously agreed amount to the designated beneficiary.

Prospective purchasers of life insurance have a number of options from which they may choose. The development of these different options and more complex policy forms demands that prospective purchasers be fully informed as to the coverage and benefits necessary to provide adequate insurance protection for their needs.

Wisconsin law attempts to protect consumers by requiring that intermediaries provide clear and unambiguous information during their sales presentations. In addition, the policies must meet certain statutory requirements in order to be sold in this state.

LIFE INSURANCE POLICIES

WHAT ARE SOME OF THE PROVISIONS WHICH ARE REQUIRED IN ALL LIFE INSURANCE POLICIES?

- Separate benefits. Every life insurance policy must specify each benefit promised in the policy.
- Grace period. Every life insurance policy must contain a provision entitling the policyholder to a grace period of not less than 31 days for the payment of any premium except the first. During the grace period the policy continues in force.

[ss. 632.44, 632.56]

EXAMPLE

- The holder of an individual term life insurance policy failed to make the second premium payment by the date on which it came due. Two weeks later the insured mailed the payment to the insurance company. Is the policy still in effect?

Yes. Under s. 632.44 (2), Wis. Stat., every life insurance policy must contain a "grace period" of not less than 31 days. Since the premium payment was submitted within 31 days after the due date, the policy will continue in effect.

WHAT IS A VARIABLE CONTRACT?

The term "contract on a variable basis" or "variable contract" means any policy or contract which provides for insurance or annuity benefits which may vary according to the investment experience of any separate account or accounts maintained by the insurer as to such policy or contract, as provided for in s. 632.45 (1), Wis. Stat.

Any contract using separate accounts which provides for payment of benefits in variable amounts must contain a statement of the essential features of the procedures the insurer will follow in determining the dollar amount of the variable benefits. It must contain appropriate nonforfeiture benefits in lieu of those under the standard nonforfeiture law.

Any individual variable contract must state that the dollar amount of benefits may decrease or increase.

Any individual variable contract must conspicuously display on its first page a statement that its benefits are on a variable basis, with a statement showing exactly where in the contract the details of the variable provisions can be found.

Any variable contract must state whether it may be amended as to investment policy, voting rights, and conduct of the business and affairs of any segregated account. Subject to any preemptive provision of federal law, any such amendment is subject to filing and approval by the Commissioner and approval by a majority of the policyholders in the segregated account.

Variable contracts may be issued only according to the terms of a general marketing plan approved by the Commissioner. The marketing plan must be designated to protect the interests of the policyholders in regard to any voting rights and operations of the segregated account and amendment of the contract.

Any intermediary selling or offering for sale a variable contract must have a valid license authorizing the solicitation of life insurance and must have passed one of the alternative security examinations listed in s. Ins 2.13 (9), Wis. Adm. Code.

[s. 632.45, s. Ins 2.13]

WHEN CAN THE INSURER CONTEST INDIVIDUAL LIFE INSURANCE POLICIES?

No individual life insurance policy may be contested after it has been in force for two years from the date of issue except for nonpayment of premiums or misstatement of age.

Disability coverages and additional accident benefits included in a life insurance contract may be contested at any time on the ground of fraudulent misrepresentation.

[s. 632.46]

WHAT HAPPENS IF THE APPLICATION FOR INSURANCE CONTAINS A MISSTATEMENT OF AGE?

If the age of the person whose life is at risk is misstated in a life insurance application and the error is not adjusted during his or her lifetime, the amount payable under the policy is what would be paid if the age had been stated correctly. The insurer is not liable for death benefits if the insured was older than the age limit designated by the insurer for issuance of the policy.

[s. 632.46(3)]

EXAMPLES

- The holder of an individual term life insurance policy was killed in an automobile accident. The insured was under the maximum age limit designated by the insurance company. The insured's wife, who was named as beneficiary, filed a claim with the insurance company for the death benefits. The company refused to honor the claim on the ground that the insured misstated his age in the application. Can the insurance company refuse payment?

No. Under s. 632.46 (3), Wis. Stat., if the age of the insured is misstated on the application for the policy and the error is not adjusted during his lifetime, the amount payable under the policy is what the premiums paid would have purchased if the age had been stated correctly.

- The holder of an individual term life insurance policy suffered a fatal heart attack four years after the policy was issued. The contract contained a two-year incontestability provision. At the time of application for insurance, the insured had mistakenly answered in writing that he had no prior physical problems with his heart, although he had been treated for minor coronary ailments including high blood pressure. Can the insurance company now refuse to pay the claim on the ground that the insured had made a material misrepresentation which allowed the company to void the policy?

No. Under s. 632.46 (1), Wis. Stat., once the policy has been in effect for two years, the insurance company may not contest the policy.

MAY RIGHTS UNDER A LIFE INSURANCE POLICY BE ASSIGNED TO ANOTHER PERSON?

The owner of any rights under an individual life insurance policy or annuity contract may assign any of those rights, including any right to designate a beneficiary. An assignment which is valid under general contract law vests the assigned rights in the assignee (the person to whom the assignment is made) subject to any provision in the insurance policy or annuity contract inserted to protect the insurer against double payment or obligation.

The rights of the beneficiary under a life insurance policy or annuity contract are subordinate to those of an assignee, unless the beneficiary was effectively designated as an irrevocable beneficiary prior to the assignment.

Assignment may be expressly prohibited by a group contract providing annuities as retirement benefits, and by an annuity that is subject to transferability restrictions under any federal or state tax, employee benefit, or securities law.

[s. 632.47]

EXAMPLES

- The owner of an individual whole life insurance policy notified the company that the rights to the death benefits were being assigned to her sister. There is no provision in the policy which restricts the policyholder's right to assign the rights under the policy. The assignment was made in writing and the owner received something of value from her sister in return. Assuming that the insured's sister was not the beneficiary under the policy, is the company obligated to pay the benefits to the sister-assignee?

Yes. The assignment is valid under general contract law and vests the assigned rights in the sister-assignee. Under s. 632.47, Wis. Stat., the rights of the sister-assignee to receive the death benefits take priority over the rights of the beneficiary.

- The holder of an individual annuity contract assigned the rights to the annuities to his friend who was not the beneficiary under the policy. The assignment was in writing and made in exchange for something of value. The policy contains a provision which expressly stated that the designation of beneficiary was irrevocable. The insured died and the friend-assignee claimed the death benefits under the assignment contract. Is the insurance company obligated to pay the benefits to the friend-assignee?

No. Under an assignment under s. 632.47, Wis. Stat., the friend-assignee takes effective rights to the death benefits unless the beneficiary was "effectively designated as an irrevocable beneficiary prior to the assignment." Since the prior policy contains such a restriction on the assignment, the assignment to the friend-assignee is subordinate to the beneficiary. The death benefits go to the designated beneficiary.

WHAT RIGHTS EXIST REGARDING DESIGNATION OF THE BENEFICIARY?

Subject to the relative rights of the assignee and the beneficiary, the policyholder of a life insurance policy or annuity contract has the unrestricted right to designate an irrevocable beneficiary or change the beneficiary if not irrevocable.

The policyholder may, at any time, make an irrevocable designation of the beneficiary effective at once or at some time in the future. If the designation of the beneficiary is not explicitly irrevocable, the policyholder may change the beneficiary without the consent or knowledge of the previously designated beneficiary.

Subject to statutory requirements as to changing the beneficiary by will of the policyholder, any act of the policyholder that unequivocally indicates an intention to make the change in beneficiaries is sufficient to effect it.

An insurer may prescribe formalities to be complied with for the change of beneficiaries which may be only for its own protection. The insurer discharges its obligation under the insurance policy if it pays a properly designated beneficiary, unless it has actual notice of either the assignment or an unequivocal act by the policyholder which indicates an intention

to change beneficiaries. The insurer has actual notice if the policyholder has complied with its prescribed formalities.

[s. 632.48]

EXAMPLES

- A holder of an individual whole life insurance policy originally named his daughter as beneficiary. The policy contained no explicit restrictions on the right to change the beneficiary. After the policy had been in effect for six months, the policyholder decided to change the beneficiary to his oldest son. After the policyholder's death, his daughter told the insurance company that she was entitled to receive the death benefits as the first beneficiary instead of the son. Is the daughter entitled to the benefits?

No. Under s. 632.48 (1) (b), Wis. Stat., if the designation of beneficiary is not explicitly irrevocable, the policyholder may change the beneficiary without the consent of the previously designated beneficiary. Assuming that the insured did not make a valid assignment of the right to the death benefits to the daughter after changing beneficiaries, the son is entitled to the benefits and not the daughter.

- A holder of an individual term life insurance policy changed the beneficiary by replacing the name of his mother with his daughter's name. The policyholder failed to notify the insurance company of the change as required by the policy. After the policyholder died, the insurance company paid the benefits to the mother who was the original beneficiary. The daughter claimed that the insurance company should have made payment to her under the policy. Was the insurance company correct in making payment to the original beneficiary?

Yes. Although the policyholder is free to change beneficiaries, under s. 632.48, Wis. Stat., the insurance company may require the policyholder to properly notify the company of any change of beneficiary. Since the policyholder failed to provide adequate notification under the terms of the policy, the insurance company discharged its obligation under the contract when it paid the properly designated beneficiary.

WHAT ARE VIATICAL SETTLEMENTS?

Viatical settlements are contracts under which a viatical settlement provider pays a portion of the expected death benefit of a life insurance policy to the life insurance policyholder prior to the death of the person. The policyholder must have a life-threatening or catastrophic illness and must agree to transfer the ownership of or the death benefit of the life insurance policy to the person paying the viatical settlement.

[s. 632.68]

ARE THERE REQUIREMENTS FOR VIATICAL SETTLEMENT CONTRACTS AND FOR THE BROKERS ARRANGING FOR THE CONTRACTS?

Yes. Viatical settlement contracts are subject to prior approval by the commissioner and must include disclosure statements, must follow statutory provisions regarding minimum payment requirements, and must allow for a 30-day right to rescind the contract. Viatical

settlement providers and brokers are required to follow statutory standards for truthful advertising and fair marketing practices.

[s. 632.68(9), (10)]

ARE THERE ANY SPECIAL REQUIREMENTS RELATING TO AIDS?

Under current Wisconsin law, insurers writing individual life insurance in Wisconsin may require applicants for insurance to be tested for the presence of the antibody to HTLV-III, and reveal whether they have obtained a test or the results of such a test. Applicants for group insurance may not be required to take a test or reveal whether they have obtained a test or the results of such a test. Insurers may only use or inquire about FDA-licensed tests.

Insurers are prohibited from denying or limiting benefits solely because the insured's death is caused by HIV infection.

An insurer may not require or request any individual to reveal whether the individual has undergone a test at an anonymous counseling and testing site or through the use of a home test kit.

[s. 631.90, s. Ins 3.53]

WHAT ARE PROHIBITED INSURANCE PRACTICES INVOLVING DOMESTIC ABUSE?

Effective November 1, 2000, insurers are prohibited from:

- Refusing to provide or renew or from cancelling a person's coverage under an individual or group policy or certificate on the basis that the person or a member of the person's family has been or is a victim of domestic abuse;
- Refusing to provide or renew or from cancelling an employer's or other group's coverage on the basis that an employee or other group member or a member of their family has been or is a victim of domestic abuse;
- Rating an individual or group policy on knowledge or suspicion that a person has been or is a victim of domestic abuse.

Individual or group life insurers also may not deny or limit benefits under an individual or group life insurance policy in the event the insured's death results from domestic abuse.

[s. 631.95]

LIFE INSURANCE MARKETING

ARE BONUSES PROHIBITED?

No life insurer or representative of a life insurer may provide any bonus, prize, award, or similar additional compensation on insurance business transacted in Wisconsin as a

result of a contest or competition among intermediaries. However, awards may be given as a recognition of merit. A merit award may not cost in excess of \$150, and the aggregate cost of all such awards in any calendar year may not exceed 1.5% of the insurer's total first-year life insurance premium income derived from sales in Wisconsin, excluding income from single premium policies.

An intermediary may receive payment to cover reasonable and actually incurred expenses in connection with any educational conference, meeting, or training course held for bona fide business or educational purposes.

[s. 628.77]

WHAT IS REPLACEMENT OF LIFE INSURANCE OR ANNUITIES?

Replacement is any transaction in which new life insurance or a new annuity is to be purchased and existing individual life insurance or an annuity has been, may possibly be, or is to be lapsed, surrendered, or converted into paid-up insurance or extended insurance, or the cash or loan value (or a portion thereof) is utilized or contemplated for use in the future in connection with the purchase of new insurance or annuities.

[s. 628.34, s. Ins 2.07(3)]

WHAT IS THE PURPOSE BEHIND REPLACEMENT PROCEDURES AND DISCLOSURE REQUIREMENTS?

The interest of life insurance and annuity policyholders must be protected by establishing minimum standards of conduct to be observed in the replacement or proposed replacement of such policies. Policyholders are protected because the opportunity for misrepresentation in replacement situations is reduced. The replacement and disclosure requirements apply to most individual life insurance and annuity contracts sold in Wisconsin.

[s. 628.34, s. Ins 2.07]

WHAT ARE THE DUTIES OF AN INTERMEDIARY REGARDING REPLACEMENT AND DISCLOSURE?

The intermediary must determine, prior to completing a new application, whether or not replacement is involved and obtain with each application for life insurance or an annuity a statement signed by the applicant as to whether the new insurance will replace existing life insurance or an existing annuity on the same life.

With each application for life insurance or an annuity, the agent must submit to the insurer the statement signed by the applicant together with a statement as to whether, to the best of the intermediary's knowledge, replacement is involved in the transaction.

[s. 628.34, s. Ins 2.07(4)(a)]

WHAT MUST INTERMEDIARIES DO IF REPLACEMENT IS INVOLVED OR PROPOSED IN THE TRANSACTION?

Where replacement is involved or proposed, the intermediary must:

- Before taking an application for life insurance or an annuity, have the applicant review and complete the applicant's portion of the prescribed replacement Notice;
- Complete the certification statement on the Notice, sign and date the Notice, and list the policy number and name of insurer of each policy which there is reason to think may be replaced;
- Leave a completed copy of the notice with the applicant for his or her records prior to completing the application for the new policy;
- Submit a completed copy of the Notice with the application to the proposed insurer;
- Maintain a copy of the Notice in the agent's file for that applicant for at least three years.

[s. 628.34, s. Ins 2.07(4)(b)]

WHAT INFORMATION IS THE AGENT REQUIRED TO COMPLETE IN THE NOTICE?

The legal name of all insurers involved, the insured's name and policy number of any policy which may be replaced, the generic name and face amount of any replacing policy, and the certification statement.

[s. Ins 2.07]

DO INDIVIDUAL AGENTS HAVE TO MAINTAIN RECORDS REGARDING SUITABILITY INQUIRIES AND REPLACEMENT PROCEDURES?

Yes. Each individual agent must maintain records for a three-year period giving the effective date of the coverage on all newly issued contracts, and indicating that the necessary suitability inquiry and replacement procedures required by ss. Ins 2.07, 2.14 (5) (f), 2.15 (9) (f), 3.27 (7), and 3.29, Wis. Adm. Code, were followed for each individual life, individual annuity, and accident and health contract written or replaced.

[s. 601.42, s. Ins 6.61]

MAY POLICIES BE DATED BACK TO A LOWER INSURANCE AGE?

An insurance company may not issue any life insurance policy with an effective date more than six months before the date of application, when the earlier date results in a lower premium than that which would have been payable based on the birthday nearest the date of application.

The date of application is considered to be the date on which the application or the medical examination is complete, whichever is later.

The exchange, alteration, or conversion of life insurance policies as of the original date of such policies is not prohibited if the amount of insurance provided under the new policy does not exceed the amount of insurance under the original policy or the amount of insurance which the premium paid for the original policy would have purchased if the new policy had been originally applied for. This section does not prohibit the exercise of any conversion privilege contained in any policy or contract.

[s. Ins 2.03]

WHAT ARE THE STANDARDS FOR LIFE INSURANCE SOLD IN CONNECTION WITH A MUTUAL FUND OR OTHER SECURITY?

Section Ins 2.09, Wis. Adm. Code, applies to the solicitation of life insurance or annuities when it is known to the insurer or the intermediary that the sale of any mutual fund or other security has been, may become, or is a part of any transaction.

Minimum standards are set out for the form of proposals and statements used to solicit, service, or collect premiums for life insurance or annuities sold in connection with a mutual fund or other security. Any bill, statement, or representation sent or delivered to any prospect or policyholder must show the premium charge and any other information mentioned concerning the life insurance or annuity separately from any other charges or values shown in the same billing.

An insurer or intermediary must provide the prospective purchaser or policyholder with a copy of a clear and unambiguous written proposal, as defined in the following section, not later than the time the solicitation or proposal is made.

[s. 628.34, s. Ins 2.09]

WHAT MUST BE INCLUDED IN THE REQUIRED PROPOSAL FOR LIFE INSURANCE AND ANNUITIES SOLD IN CONNECTION WITH A MUTUAL FUND OR OTHER SECURITY?

Any proposal under s. Ins 2.09, Wis. Adm. Code, must be dated and signed by the intermediary or by the insurer if no agent is involved. It must state the name of the company, be accurate and complete, contain no misrepresentation or false, deceptive or misleading statements, and show the premium charge for the life insurance or annuity separately from any other charge.

In addition, the proposal must:

- Show the value of the life insurance or annuity separately from any other values if the values which may accrue prior to the death of the insured are involved in the presentation;

- Show the amount of the death benefit for the life insurance separately from any other benefit which may accrue upon the death of the insured if it is involved in the presentation;
- Set forth all matters pertaining to life insurance or annuities separately from any matter not pertaining to life insurance or annuities; and
- Contain only such representations as will accurately reflect the actual conditions applicable to the proposed insured.

[s. 628.34, s. Ins 2.09(6)]

WHAT ARE THE DISCLOSURE REQUIREMENTS FOR THE SALE OF LIFE INSURANCE?

The interests of prospective purchasers of life insurance must be safeguarded by providing persons with clear and unambiguous statements, explanations, and written information concerning the life insurance contracts offered to them. Section Ins 2.14, Wis. Adm. Code, specifies that certain information must be disclosed to prospective purchasers. The purpose of the rule is to require insurers to deliver to purchasers of life insurance information which will improve the buyer's ability to select the most appropriate plan of life insurance for his or her needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration, and improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

The insurer must provide a Policy Summary upon delivery of the policy only if the insurer does not provide a basic illustration. The policy summary may describe or illustrate only the guaranteed elements of the policy. Dividends and other nonguaranteed elements cannot be shown. The policy summary must show the annual premiums, guaranteed amount payable upon death, and guaranteed cash surrender values, for the first 20 policy years and at least one age from 60 through 65 or maturity, whichever is earlier.

The insurer shall provide to all prospective purchasers of life insurance policies subject to the rule a copy of the Life Insurance Buyer's Guide at the time the application is taken, except that insurers which do not market policies through an intermediary may provide the buyer's guide at the time the policy is delivered provided they guarantee to the policyholder a 30-day right to return the policy for a full refund of premium.

Prior to beginning a life insurance sales presentation, an intermediary must inform a prospective purchaser that he or she is acting as a life insurance intermediary and inform the prospective purchaser of the full name of the insurer which the intermediary is representing. Where an intermediary is not involved, the insurer must identify its full name.

[s. Ins 2.14]

WHAT IS A POLICY SUMMARY?

A Policy Summary means a written statement, in substantially the same format for all companies, which describes only the guaranteed elements of the life insurance policy, including but not limited to:

- The title of Statement of Policy Cost and Benefit Information;
- Name and address of the intermediary and insurer;
- Generic name of the basic policy and each rider;
- Amounts, where applicable, for the first 20 policy years and at least one age from 60 through 65 or maturity, whichever is earlier, the annual premium for the basic policy, annual premium for each optional rider, guaranteed amount payable upon death, total guaranteed cash surrender values, and guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values;
- Effective policy loan interest rate, stated as an annual percentage;
- Date on which the Policy Summary is prepared.

A policy summary is not required if the insurer uses a basic illustration that complies with s. Ins 2.17.

[s. Ins 2.14]

WHAT IS A LIFE INSURANCE ILLUSTRATION?

Illustration means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years. A basic illustration means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

WHAT ARE THE REQUIREMENTS FOR THE USE OF LIFE INSURANCE ILLUSTRATIONS?

This rule provides requirements for life insurance policy illustrations that will protect consumers and foster consumer education. The rule provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations. The illustration rule applies to all group and individual life insurance policies and certificates except:

- Variable life insurance
- Individual and group annuity contracts
- Credit life insurance
- Life insurance policies with no illustrated death benefits on any individual exceeding \$10,000.

WHAT MUST BE INCLUDED IN AN ILLUSTRATION?

An illustration must be clearly labeled "life insurance illustration" and must contain all of the following basic information:

- Name of insurer
- Name and business address of agent or insurer's authorized representative
- Name, age and sex of the proposed insured
- Underwriting or rating classification upon which the illustration is based
- Generic name of the policy, the insurer's product name and form number
- Initial death benefit
- Dividend option election or application of non-guaranteed elements, if applicable

WHAT IS AN INSURER OR AGENT PROHIBITED FROM DOING WHEN USING ILLUSTRATIONS IN THE SALE OF A LIFE INSURANCE POLICY?

Insurers and agents shall not:

- Represent the policy as anything but life insurance
- Use or describe non-guaranteed elements in a manner that is misleading
- State or imply that payment of a non-guaranteed element is guaranteed
- Use an illustration that does not comply with the Life illustrations rule, s. Ins 2.17
- Use an illustration that at any policy duration depicts results more favorable than that produced by the illustrated scale of the insurer whose policy is being illustrated
- Provide an applicant with an incomplete illustration
- Represent that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits unless such representation is fact
- Use the terms "vanish", "vanishing premium", or similar language which implies that a policy will become paid up based on the use of non-guaranteed elements to pay premiums
- Use an illustration that is "lapse-supported" unless illustrating a policy that can never develop nonforfeiture values
- Use an illustration that is not "self-supporting"
- Illustrate an interest rate that is greater than the earned interest rate underlying the disciplined current scale

WHAT ARE THE REQUIREMENTS FOR DELIVERY OF ILLUSTRATIONS AND RECORD RETENTION?

If a policy is marketed with an illustration, a signed copy of the illustration must be provided to the applicant and must be submitted to the insurer at the time of policy application. If the policy is issued other than as applied for, a new basic illustration entitled "Revised illustration" conforming to the policy as issued shall be sent to the policyholder with the policy. The revised illustration shall be signed and dated by the applicant or policyowner and the agent no later than the time the policy is delivered.

The insurer shall maintain copies of all signed illustrations for a minimum of three years after the policy is no longer in force.

WHEN ARE ANNUAL REPORTS TO POLICYHOLDERS REQUIRED AND WHAT IS REQUIRED IN THE REPORT?

If an insurer uses an illustration in selling a policy, the insurer shall provide the policyowner with an annual report on the status of the policy that must contain at least the following information:

- The beginning and end date of the current report period;
- The policy value at the end of the previous report period and at the end of the current report period;
- Premiums paid;
- Current death benefit;
- Current cash surrender value;
- Current dividends and application of current dividend;
- Amount of outstanding loans.

Policyowners will also receive information as to how to obtain an inforce illustration.

[s. Ins 2.17]

WHAT OTHER REQUIREMENTS MUST BE MET WHEN SELLING LIFE INSURANCE?

- Each insurer must maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to s. Ins 2.14, Wis. Adm. Code. The file must contain one copy of each authorized form for a period of three years following the date of its last authorized use.
- Terms such as "financial planner," "investment adviser," "financial consultant," or "financial counselling" may not be used in such a way as to imply that the insurance intermediary is generally engaged in an advisory business in which compensation is unrelated to sales unless this is actually the case.
- Any reference to policy dividends must include a statement that dividends are not guaranteed.
- No sales presentation may state or imply that life insurance arrangements are the same as savings accounts or deposits in banking or saving institutions, nor can terms such as "investment," "investment plan," "deposit," "profit sharing," "interest plan," "savings," or "savings plan," or other similar terms be used in a context or under circumstances that would have the capacity or tendency to mislead a purchaser or prospective purchaser to believe that he or she will receive something other than a life insurance policy or will receive some benefit not available to other persons of the same class and equal expectation of life.
- The purchase or replacement of any life insurance contract or annuity may not be recommended by any insurer or intermediary without reasonable grounds to believe that the recommendation is not unsuitable for the applicant on the basis of information furnished by the applicant after the insurer or intermediary has made whatever

reasonable inquiry is necessary under the circumstances concerning the prospective buyer's insurance and annuity needs and means.

- A system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments may not be used for comparing the cost of two or more life insurance policies.
- Except for an illustration as defined in s. Ins 2.17, no presentation of benefits may display guaranteed and nonguaranteed benefits as a single sum unless they are shown separately in close proximity to each other and with equal prominence.
- Insurers or agents must conduct a reasonable investigation as to the suitability for the prospective purchaser of a life insurance or annuity product.

[s. Ins 2.14]

ARE THERE SPECIFIC REQUIREMENTS RELATING TO ADVERTISEMENTS, REPRESENTATIONS, SOLICITATIONS, AND MARKETING OF LIFE INSURANCE AND ANNUITIES?

Yes. Major requirements include, but are not limited to, the following:

- Advertisements may not contain deceptive words, symbols, or illustrations if they exaggerate, overstate, understate, or contain incomplete information regarding a life insurance or annuity product.
- Advertisements must clearly identify the insurer and may not use words or symbols that imply government sponsorship of the insurer.
- Advertisements must disclose whether the person giving an endorsement is being paid for doing so. This does not apply if the person making the testimonial, endorsement, or statement holds a Wisconsin Insurance intermediary license, or if the person is a radio or television announcer that is employed or compensated on a salaried or union wage scale basis.
- Advertisements must disclose if a product has nonlevel premiums or if the insurer may change the amount of premium due during the policy term.
- Advertisements may not state or imply that the payment or amount of nonguaranteed policy elements are guaranteed.

[s. Ins 2.16]

WHAT ARE THE DISCLOSURE REQUIREMENTS FOR SALES OF ANNUITIES?

Insurers are required to give applicants for deferred annuity contracts or deposit funds or riders sold in conjunction with insurance policies or annuity contracts, information which helps them evaluate the relative benefits of similar plans.

These regulations do not apply to:

- Variable annuities;
- Contracts registered with the Federal Securities and Exchange Commission;
- Group annuity and pure endowment contracts purchased under a retirement plan or plans of deferred compensation established or maintained by an employer or employee organization;
- Immediate annuity contracts;
- Policies issued in connection with employee benefit plans covered by ERISA;
- Individual retirement accounts;
- Single advance payment of specified premiums equal to the discounted value of such premiums;
- A policyholder's deposit account established solely to facilitate payment of regular premiums; and
- Settlement options under life insurance or annuity contracts.

Insurers and intermediaries must give annuity buyers covered by the rule a copy of the current edition of the Wisconsin Buyer's Guide to Annuities and a Preliminary Contract Summary or a Contract Summary prior to accepting the applicant's initial consideration for the annuity contract. In the case of a rider, these items must be given prior to accepting the applicant's initial premium.

[s. Ins 2.15]

WHAT MUST THE PRELIMINARY CONTRACT SUMMARY INCLUDE?

The Preliminary Contract Summary must include:

- The title, contract summary, and an identification of the arrangement to which the statement applies;
- The name and address of the insurance intermediary or a statement of the procedure to be followed in order to receive responses to inquiries;
- The name and home office or administrative office address of the insurer;
- A statement as to whether the arrangement provides any guaranteed death benefits during the deferral period;
- A prominent statement that the contract does not provide cash surrender values, if that is the case;

- A statement that the contract may result in loss if kept for only a few years, if that is the case;
- Any minimum or maximum premium limitations;
- A prominent description of all fees, charges, and loading amounts that are or may be deducted from initial or subsequent considerations paid or that may be deducted from the contract or fund values prior to or at contract maturity; and
- In the event any sales presentation illustrates values or annuity payments which are based on dividends or current annuity rates, a statement that these values and annuity amounts are illustrations only and are not guaranteed.

[s. 628.34, s. Ins 2.15]

WHAT IS THE STATE LIFE INSURANCE FUND?

The State Life Insurance Fund (Fund) is a state-sponsored, nonprofit, mutual program which offers low-cost life insurance to the residents of the state of Wisconsin. The Fund does not use licensed intermediaries, does not advertise, and is exempt from federal income tax. Policies can be bought through the Office of the Commissioner of Insurance of the state of Wisconsin. Evidence of insurability must be provided. This is not an automatic coverage. The Fund is required to operate in a manner consistent with private insurers in regard to policy coverage, medical examinations, and underwriting procedures.

The Fund issues term and whole life policies. The maximum coverage available under the Fund is \$10,000.

[ch. 607]

CHAPTER VI

PROPERTY AND CASUALTY INSURANCE

Property and casualty insurance may generally be said to include all kinds of insurance other than life and disability. Specifically, it includes, but is not limited to: fire, other perils, inland marine and ocean marine, liability, steam boiler, fidelity, surety, credit, title, burglary, robbery, theft, glass breakage, worker's compensation, automobile liability and physical damage, mortgage guaranty, legal expense, and other miscellaneous lines.

RATES

DO RATES HAVE TO BE FILED?

Every authorized insurer and every rate service organization (licensed under Wisconsin law and designated by the insurer for the filing of rates) must file with the Commissioner all rates, all supplementary rate information, and all changes and amendments to the rates made by it for use in Wisconsin within 30 days after the rates become effective. Except for worker's compensation rates and the rates by used by the Wisconsin Automobile Insurance Plan and the Wisconsin Insurance Plan, no prior approval of rates for property and casualty insurance is required. However, the Commissioner may call a hearing to disapprove rates.

[ss. 625.13, 625.22, 626.13, ss. Ins 3.49(3), 4.10(7)(g)]

WHAT ABOUT GENERAL RATE STANDARDS FOR PROPERTY AND CASUALTY INSURANCE?

Except for those cases cited in the previous section, the insurance Commissioner's office does not approve rates for policies sold in this state. Companies do file the rates they are using.

The Commissioner's office has the authority to disapprove rates if they are excessive, inadequate or unfairly discriminatory.

Rates are presumed to be not excessive if a reasonable degree of price competition exists at the consumer level with respect to the class of business to which they apply. If such competition does not exist, rates are excessive if they are likely to produce a long run profit that is unreasonably high in relation to the services rendered.

A rate is inadequate if, together with the investment income attributable to it, it is clearly insufficient to sustain projected losses and expenses in the class of business to which it applies.

A rate is unfairly discriminatory in relation to another in the same class if it clearly fails to equitably reflect the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long

as the rate reflects the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise, or blanket policy.

[s. 625.11]

ARE THERE ANY EXCEPTIONS TO THE GENERAL RATE STANDARDS AND RATE FILING REQUIREMENTS?

Yes. Inland marine risks, risks written on a consent-to-rate basis or individually rated and certain title insurance rates are exempt from the rate filing requirements. Worker's compensation insurance is totally exempt from the general rate standards and rate filing requirements because there is a separate rate law for worker's compensation insurance in Wisconsin.

Although worker's compensation rates shall not be excessive, inadequate or unfairly discriminatory, the worker's compensation rate law is a prior approval law, and the rates used in Wisconsin are uniform. All insurers writing worker's compensation insurance in Wisconsin must be members of the Wisconsin Compensation Rating Bureau, and by law, they must use the rates and the forms filed by the Bureau without exception or deviation. Rates are filed by the Bureau and must be approved by the Commissioner prior to use.

[s. 626.13, ss. Ins 4.08, 6.78]

WHAT CLASSIFICATION OF RISKS ARE PROHIBITED FOR RATING PURPOSES?

Section Ins 6.54, Wis. Adm. Code, applies to all contracts issued, renewed, or amended which provide automobile coverage, coverage for loss or damage to real property used for residential purposes for not more than four living units, or coverage for loss or damage to personal property used for residential purposes.

An insurance company may not refuse, cancel, or deny insurance coverage to a class of risk solely on the basis of any of the following factors (taken individually or in combination), nor may it place a risk in a rating classification based on any of the following factors without credible information supporting such a classification and demonstrating that it equitably reflects differences in past or expected losses and expenses:

- The applicant's or insured's past criminal record;
- The applicant's or insured's physical condition or developmental disability;
- The applicant's or insured's past mental disability;
- The applicant's or insured's age;
- The applicant's or insured's marital status;

- The applicant's or insured's sexual preference;
- The applicant's or insured's "moral" character.

However, none of the above factors includes as a prohibited practice any of the following:

- Denying, cancelling, or nonrenewing automobile or property insurance of a person convicted of an offense directly related to the risk to be insured;
- Establishing a classification system merely for the purpose of developing statistical data;
- Underwriting only a class of risks which are specified in the insurer's articles of incorporation;
- Establishing a rate based on the record of all drivers of an insured automobile;
- Establishing a rate based on the number of people residing in the household.

In addition, an insurer may not require an applicant or insured to undergo a physical examination to obtain or continue coverage unless the cost of the examination is borne by the insurer.

[s. 628.34, s. Ins 6.54]

DO FORMS HAVE TO BE FILED?

Generally, under Wisconsin law, any form which becomes a part of an insurance contract must be approved by the Commissioner of insurance prior to its use by an insurer.

[s. 631.20, s. Ins 6.05]

PROPERTY INSURANCE

WHAT MUST PROPERTY INSURANCE FORMS CONTAIN?

Property insurance was traditionally based upon what is known as the "standard fire policy." This standard fire policy was entirely set out in the statutes and provided coverage only for fire, lightning, and removal from the premises of property endangered by a covered peril. However, broader coverage against other dangers and kinds of loss could be provided by the attachment of various endorsements to the standard fire policy.

Thus, every policy which included fire coverage, alone or in connection with other coverage, was required by law to include the complete standard fire policy, even if its standard terms were inconsistent with conditions and terms of other endorsements. In 1976, the "standard fire policy" was removed from the statutes, to allow for the gradual development of other types of property insurance forms.

To assist this development, s. Ins 6.76, Wis. Adm. Code, was promulgated. This regulation sets out characteristics and authorized provisions for property insurance forms.

Any fire, inland marine, or other property insurance form may be disapproved as misleading, deceptive or obscure by the Commissioner if it does not clearly state the perils covered, the limitations and the conditions; if it contains provisions contrary to the law, or if it does not include clauses covering the following provisions when appropriate:

- Location and description of the property covered;
- Effect of other insurance on the coverage provided;
- Conditions suspending, restricting, or voiding the coverage provided;
- Termination of the contract;
- Mortgagee interests and obligations; and
- Obligations in case loss occurs.

[s. 628.34, s. Ins 6.76]

WHAT IF THERE IS A TOTAL LOSS?

Whenever any policy insures real property which is owned and occupied by the insured as a dwelling and the property is wholly destroyed without criminal fault on the part of the insured, the amount of the loss shall be taken conclusively to be the policy limits of the policy insuring the property.

[s. 632.05, s. Ins 4.01]

MAY REPLACEMENT COST COVERAGE BE ISSUED?

In a property insurance policy, an insurer may agree to indemnify the insured for the amount it would cost to repair, rebuild, or replace the damaged or destroyed insured property with new materials of like size, kind, and quality.

[s. 632.05]

WHAT ARE MORTGAGE CLAUSES?

A provision for payment to a mortgagee (person who lends the money) or other owner of a security interest in property may be contained in or added by endorsement to any property insurance policy. If the provision is contained in an endorsement and the insurance covers real property, any loss not exceeding \$500 must be paid to the insured mortgagor (person taking out the mortgage).

[s. 632.08]

WHAT ARE THE LIMITATIONS ON USING UNDERWRITING INFORMATION INVOLVING DOMESTIC ABUSE?

Property and liability insurers are prohibited from taking the following actions:

- Refusing to provide or renew or from cancelling a person's coverage under an individual or group policy or certificate on the basis that the person or a member of the person's family has been or is a victim of domestic abuse;
- Refusing to provide or renew or from cancelling an employer's or other group's coverage on the basis that an employee or other group member or a member of their family has been or is a victim of domestic abuse;
- Rating an individual or group policy on knowledge or suspicion that a person has been or is a victim of domestic abuse;
- Under policies that exclude coverage for loss or damage resulting from intentional acts, insurers may not deny payment to an innocent insured for damage or loss that resulted from an act of abuse or domestic abuse, if the insured did not cooperate in or contribute to the loss or damage and the person who committed the act is criminally prosecuted.

[s. 631.95(2)]

WHAT ARE THE LIMITATIONS ON USING OR DISCLOSING INFORMATION ABOUT DOMESTIC ABUSE?

Persons employed by or contracted with an insurer may not use, disclose, or transfer information relating to whether a person is or has been a victim of domestic abuse, and may not disclose or transfer that person's telephone number or address, except for a purpose related to the provision of health care services or for a valid business purpose, including disclosure or transfer of information to a reinsurer, the insurer's attorney, medical, underwriting or claims personnel under contract with the insurer, the policyholder's assignee, in response to a legal process, or as required by court order or by order of OCI. An insured or applicant may also obtain his or her own insurance records from an insurer.

[s. 631.95(5)]

LIABILITY INSURANCE

MAY LIABILITY POLICIES CONTAIN "APPRAISAL" OR "ARBITRATION" PROVISIONS?

An insurance policy may contain a provision for independent appraisal and compulsory arbitration, provided that the provision meets the statutory requirements for approval of forms under s. 631.20, Wis. Stat., and is approved by the Commissioner.

If an approved policy provides for application to a court for the appointment of a disinterested appraiser, arbitrator, or umpire, any court of record in Wisconsin except the Court of Appeals or the Supreme Court may be requested to make an appointment.

Upon appropriate request, the court is required to make the appointment of a disinterested person promptly.

[s. 631.85]

WHAT PROVISION ON BANKRUPTCY OR INSOLVENCY IS REQUIRED IN LIABILITY INSURANCE POLICIES?

Every liability insurance policy must provide that the bankruptcy or insolvency of the insured will not diminish any liability of the insurer to third parties. Insolvency of the insured does not excuse the insurer from payment. If execution of a judgment by the injured party against the insured is returned unsatisfied, legal action may be maintained against the insurer to the extent that the liability is covered by the policy.

[s. 632.22]

MAY AN INJURED THIRD PARTY MAINTAIN A "DIRECT" LEGAL ACTION AGAINST THE INSURER UNDER A LIABILITY POLICY ISSUED IN WISCONSIN?

Any bond or insurance policy covering liability to others for negligence makes the insurer liable to persons entitled to recover against the insured for the death or injury to persons or property. The insurer is liable up to the amounts stated in the bond or policy, irrespective of whether the liability has already been established, or is dependent upon a final judgment against the insured.

[s. 632.24]

WHAT NOTICE PROVISIONS ARE REQUIRED FOR LIABILITY INSURANCE POLICIES?

Every liability insurance policy must contain a provision that notice given by the policyholder to any authorized intermediary of the insurer in Wisconsin, with enough specific information to identify the insured, constitutes proper notice to the insurer.

If the contract contains a provision concerning failure by the policyholder to give any notice within the time specified, the provision does not invalidate the insured's claim if it is shown that it was not to have been reasonably possible to give notice on time and that notice was given as soon as reasonably possible.

[s. 632.26(1)]

WHAT COVERAGE PROVISIONS ARE REQUIRED FOR AUTOMOBILE LIABILITY POLICIES?

Every liability policy issued or delivered in Wisconsin to the owner of a motor vehicle must provide that:

Any coverage provided to the named insured must also apply to any person using any motor vehicle described in the policy when the use is for purposes and in the manner described in the policy. This coverage extends to any person legally responsible for the use of the motor vehicle.

The policy may limit the coverage to instances in which the riding, use, or operation is with the permission of the named insured, or when the insured is an individual with the permission of an adult member of the insured's household other than a chauffeur or domestic servant.

[s. 632.32]

WHAT COVERAGE IS REQUIRED UNDER THE "UNINSURED MOTORIST" PROVISION IN AUTOMOBILE LIABILITY INSURANCE POLICIES?

Every motor vehicle liability insurance policy which:

- Is delivered or issued for delivery in Wisconsin on any motor vehicle registered or principally garaged in Wisconsin; and
- Insures against loss resulting from liability imposed by law for bodily injury or death suffered by persons arising out of the ownership, maintenance, or use of a motor vehicle.

Shall contain provisions such that:

The insurer must provide in the policy, or supplemental to the policy, coverage for bodily injury or death in the amount of at least \$25,000 per person and \$50,000 per accident under provisions approved by the Commissioner. This provision is for the protection of injured persons who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness or disease, or death.

The term "uninsured motor vehicle" includes an insured motor vehicle if before or after the accident, the liability insurer of the motor vehicle is declared insolvent in court. An uninsured motor vehicle also includes an unidentified motor vehicle involved in a hit-and-run accident.

[s. 632.32(4)(a)]

WHEN IS CANCELLATION OR NONRENEWAL OF AN AUTOMOBILE LIABILITY INSURANCE POLICY PROHIBITED?

No insurer may cancel or refuse to issue or renew an automobile insurance policy wholly or partially because of one or more of the following characteristics of any person: age, sex, residence, race, color, creed, religion, national origin, ancestry, marital status, or occupation.

[s. 632.35]

WHAT ARE THE REQUIREMENTS FOR MOTOR VEHICLE REPLACEMENT PARTS?

The name or logo of the manufacturer of the replacement parts used in the repair of a motor vehicle must be affixed or inscribed on the replacement parts and must be visible to the extent possible after installation.

An insurer or the insurer's representative may not require the use of a nonoriginal manufacturer replacement part in an insured's motor vehicle unless the insurer or the insurer's representative gives the insured prescribed notice. The notice must be in writing. If the notice is initially given over the phone, a written disclosure must follow the phone notification.

[ss. 100.44, 632.38]

CAN DOT ODOMETER DATA BE USED TO ADJUST RATES?

No. Odometer data collected by the Wisconsin Department of Transportation (DOT) during emission inspections and obtained by an insurer from DOT may not be used as the sole rate factor for a motor vehicle liability insurance policy or as a reason in altering premium rates during the term or at the renewal of such a policy. Such data may be used as a basis for investigating the number of miles the motor vehicle is usually driven.

[s. 632.365]

ARE THERE SPECIAL REQUIREMENTS FOR MOTOR VEHICLE GLASS REPAIR?

An insurer may not require that motor vehicle glass repairs or parts be supplied by a particular vendor or at a specific location. Lists supplied by an insurer of motor vehicle repair vendors or locations which function to limit the choice of a vendor to one named on the list are prohibited.

[s. 632.37]

WHAT ARE THE REQUIREMENTS FOR "UNDERINSURED MOTORIST" COVERAGE IN AUTOMOBILE LIABILITY INSURANCE POLICIES?

For new auto policies which do not contain underinsured motorist coverage, the insurer must include a separate notice of the availability of underinsured motorist coverage and provide a brief description of the coverage along with the delivery of the policy. The insurance customer may reject underinsured motorist coverage. Underinsured motorist coverage must have limits of at least \$50,000 per person and \$100,000 per accident.

[s. 632.32 (4m)]

WHAT IS THE RESPONSIBILITY OF THE SPONSOR OF A MINOR WHO OPERATES A MOTOR VEHICLE?

Any negligence or willful misconduct of a person under the age of 18 years when operating a motor vehicle upon Wisconsin highways is a responsibility of the parents where both have custody of the minor and either parent signed as sponsor on the minor's application for a driver's license. In all other cases, any such negligence or willful misconduct is a responsibility of the adult sponsor who signed the application for the minor's license. The parents or the adult sponsor are jointly and severally liable with the minor for any damages caused by the minor's negligence or willful misconduct.

[s. 343.15]

WHAT IS "PROOF OF FINANCIAL RESPONSIBILITY" OR "PROOF OF FINANCIAL RESPONSIBILITY FOR THE FUTURE" IN AUTOMOBILE LIABILITY POLICIES?

"Proof of financial responsibility" or "proof of financial responsibility for the future" is the ability to pay damages for accidents which occur after the proof has been offered and which arise out of maintenance or use of a motor vehicle. The person must be at least able to pay \$25,000 because of bodily injury to or death of one person in any one accident, \$50,000 because of bodily injury to or death of two or more persons in any one accident and \$10,000 because of injury to or destruction of property of others in any one accident.

[s. 344.01]

WHAT PERSONS ARE REQUIRED TO SHOW PROOF OF FINANCIAL RESPONSIBILITY?

Proof of financial responsibility for the future must be furnished by any person who has had his or her driver's license and registration revoked for nonpayment of a legal judgment award arising out of a motor vehicle accident.

Proof of financial responsibility for the future must also be shown by any person who wants to have his or her driving privilege reinstated after revocation on grounds listed in ch. 343, Wis. Stat.

One way to show proof of financial responsibility is by filing a certificate of insurance (Form SR-22) with the Wisconsin Department of Transportation, Division of Motor Vehicles.

The written certificate certifies that the insurer has a motor vehicle liability policy for the benefit of the person required to furnish proof of financial responsibility. The certificate must give the effective date of the motor vehicle liability policy, and must certify coverage for any motor vehicle operated by the named insured.

[ss. 344.29, 344.30, 344.31]

WHAT USES MAY NOT BE EXCLUDED BY MOTOR VEHICLE LIABILITY POLICIES?

No policy may exclude from the coverage afforded or benefits provided:

- Persons related by blood or marriage to the insured.
- Any person who is a named insured or passenger in or on the insured vehicle.
- Any person of an age authorized to drive a motor vehicle solely for reasons of age.
- Any use of the motor vehicle for unlawful purposes, or for transportation of liquor in violation of law, or while the driver is under the influence of intoxicating liquors or narcotics or any use of the motor vehicle in a reckless manner.

[s. 632.32(6)(b)]

WHAT MEDICAL PAYMENT COVERAGE IS REQUIRED FOR MOTOR VEHICLE LIABILITY POLICIES?

Every motor vehicle liability policy which:

- Is delivered or issued with respect to any motor vehicle registered or principally garaged in Wisconsin; and
- Insures losses arising from liability for death or bodily injury of a person as a result of the ownership, maintenance, or use of a motor vehicle;

Shall contain provisions such that:

The insurer must provide in the policy or supplemental to it, under provisions approved by the Commissioner, medical payments or chiropractic payments or both in the amount of at least \$1,000 per person for protection of all persons operating or riding in the insured vehicle from losses resulting from bodily injury or death.

The named insured may reject such coverage. If the named insured rejects the coverage, it need not be provided in a subsequent renewal policy issued to such person by the same insurer unless the insured requests it in writing. Under the medical or chiropractic payments coverage, the insurer is subrogated to the rights of its insured to the extent of its payments.

[s. 632.32(4)(b)]

EXAMPLE

- A Wisconsin driver carried automobile insurance under a motor vehicle liability policy. While driving a friend to the grocery store, the insured driver hit a parked delivery truck in the store's parking lot. The friend suffered facial cuts and back injuries. Is the insured's liability to the friend covered?

Yes. Under s. 632.32 (4) (b), Wis. Stat., every such policy must provide liability coverage for bodily injury, sickness, or disease, including death, suffered by any person who is a passenger in or on the insured motor vehicle, unless the named insured had rejected the coverage.

ARE THERE LIMITS ON WRONGFUL DEATH ACTIONS?

Yes. State law limits wrongful death actions for loss of society and companionship. Judgment for damages for pecuniary injury from wrongful death may be awarded to any person entitled to bring a wrongful death action. The additional damages limit is \$350,000 or \$500,000 in the case of a deceased minor.

[s. 895.04(4)]

WHAT ARE THE NOTICE REQUIREMENTS WHEN A CERTIFIED MOTOR VEHICLE LIABILITY POLICY IS CANCELLED OR TERMINATED?

When an insurer has certified a motor vehicle liability policy as proof of financial responsibility, the certified insurance may not be canceled or terminated until at least 10 days after a notice of cancellation or termination of the certified insurance has been filed with the Wisconsin Department of Transportation, Division of Motor Vehicles. A certified insurance policy may not be canceled or terminated by the insurer on the grounds of failure to pay a premium when due prior to the expiration of 90 days from the effective date of certification.

A newly certified policy will, on the effective date of its certification, terminate any insurance previously certified. Any certification or recertification filed by the same insurer following cancellation must be accompanied by a \$3.00 fee payable by the insurer.

[s. 344.34]

WHAT ARE THE LIMITATIONS ON THE INSURER'S "DEFENSE OF NONCOOPERATION" IN MOTOR VEHICLE LIABILITY POLICIES?

If a policy of automobile liability insurance provides a defense to the insurer for lack of cooperation on the part of the insured, the defense may not be used against a third person making a claim against the insurer unless there was collusion between the third person and the insured or unless the claimant was a passenger in or on the insured vehicle. If the defense may not be used against the claimant, after payment the insurer is subrogated to the insured to the extent of the payment and is entitled to reimbursement by the insured.

[s. 632.34]

TITLE INSURANCE

MAY THE TITLE INSURER EVER CHARGE A RATE DIFFERENT FROM THE TITLE INSURER'S FILED RATE?

Yes, provided that the rate is not unfairly discriminatory [s. 628.34 (3), Wis. Stat.] and the modified rate is lower than the filed rate and the insurer keeps for at least five years after the inception of the policy:

- A record of the rate development;
- A record of the effective date of the policy, the location of the risk;
- The reason for the deviation; and
- A record of the deviated rate development.

Prior to entering into such insurance agreements, the insurer has notified the Commissioner of Insurance of its intention to do so identifying the contemplated rate deviation program.

[s. Ins 6.78(4)]

WHAT ARE UNFAIR PRACTICES?

Current law prohibits unfair practices in the transaction of the business of title insurance in Wisconsin. It contains a list of prohibited practices which constitute unfair marketing banned by ch. 628, Wis. Stat. The list prohibits offering free benefits, services, equipment or space, and anticipates that the title agent will charge fees and premiums that relate to the service or insurance provided.

[ch. 628, s. Ins 3.32]

CAN A TITLE AGENT PAY A REALTOR FOR HIS TITLE REFERRALS?

No. The rule prohibits title insurers and their agents from paying producers of title insurance and affiliates of producers of title insurance for referral of title insurance orders.

[s. Ins 3.32(4)(j)]

HOW ARE THE TERMS "AFFILIATE" AND "AFFILIATE PRODUCER" DEFINED?

"Affiliate" of a person means any other person who controls, is controlled by, or is under common control with the first person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of persons manage the two corporations.

"Affiliate producer" is a title insurance term meaning any lender, real estate broker, or representative in a transaction that results in the application for title insurance. An "affiliate producer" is also any party which receives more than 40% of its title-related revenues from one title insurer, agency, or agent. An "affiliate producer" is a "producer of title insurance."

[s. Ins 3.32(3)]

WHO IS A PRODUCER OF TITLE INSURANCE?

A producer of title insurance means any owner or prospective owner of real or personal property; any lender or prospective lender; any agent, representative, attorney, or employee of any owner or prospective owner, or of any lender or prospective lender; or any affiliated producer.

[s. Ins 3.32(3)]

MAY A TITLE INSURER ADVERTISE IN PUBLICATIONS DISTRIBUTED BY LENDERS, REAL ESTATE BROKERS, OR ATTORNEYS?

Yes. Advertising is permitted if the consideration paid is reasonable and any title insurer may advertise.

[s. Ins 3.32]

WORKER'S COMPENSATION

WHAT IS WORKER'S COMPENSATION?

Worker's compensation is protection mandated by state law for a worker and his or her dependents against injury and death occurring in the course of employment. It is not health insurance and is not intended to compensate for disability other than disability caused by accidental injury arising out of employment.

Wisconsin worker's compensation laws are administered by the Worker's Compensation Division of the Department of Workforce Development. The chief duties of the division are to handle and enforce claims for compensation against employers and to secure recovery of compensation benefits by employees.

The purpose of worker's compensation statutes is to provide financial and medical benefits to the victims of "work-connected" injuries and their families regardless of fault. The laws place the financial burden on the employer and, ultimately, the consumer. This compensation is generally the exclusive remedy for the injured employee.

[ch. 102]

WHO IS AN "EMPLOYER" UNDER WORKER'S COMPENSATION?

Under Wisconsin law, virtually all employers are required to carry worker's compensation coverage. An employer is defined as any of the following:

- The state, each county, city, town, village, school district, drainage district, and other public or quasi-public corporation within these political subdivisions;
- Every person who usually employs three or more employees whether in one or more trades, businesses, professions, or occupations, and whether in one or more locations;
- Every person who usually employs fewer than three employees, provided that the person has paid wages of \$500 or more in any calendar quarter for services performed in Wisconsin. An employer becomes subject to the worker's compensation requirements on the first day of the calendar year next succeeding such quarter;
- In general, farmers or farm labor do not come under the definition of employer, unless the person engaged in farming employs six or more employees on at least 20 days during the calendar year.

[s. 102.04]

WHO IS AN "EMPLOYEE" UNDER WORKER'S COMPENSATION?

An employee is defined under Wisconsin law as any of the following:

- Every person, including all officials, in the service of the state, or of any municipality in Wisconsin;
- Any peace officer during the performance of his or her duty;
- Every person in the service of another under any contract of hire, and all helpers and assistants to employees if they are employed with the knowledge of their employer, including minors. This does not include domestic servants, or any person whose employment is not in the course of a trade, business, profession, or occupation of an employer, unless the employer has elected to include such persons under the employer's worker's compensation coverage;
- Persons selling or distributing newspapers or magazines, or persons who are members of volunteer fire departments or fire departments organized under Wisconsin law pertaining to firemen's associations;
- Every independent contractor who does not maintain a separate business and who does not hold himself or herself out to and render service to the public, provided that the person is not an employer as defined under the preceding section.

[s. 102.07]

WHAT IS THE RESPONSIBILITY OF THE EMPLOYER UNDER WORKER'S COMPENSATION?

An employer liable under Wisconsin law to pay compensation must insure payment of compensation by contracting for such coverage with an insurer authorized to insure such liability in Wisconsin, unless the employer is exempted by the Department of Workforce Development.

[s. 102.28]

IS THERE THIRD-PARTY LIABILITY UNDER WORKER'S COMPENSATION?

Filing a claim for worker's compensation against an employer or insurer for injury or death of an employee does not affect the right of the employee, or the employee's personal representative, or any other person entitled to bring and maintain a legal action for personal injury or death against a third party.

The filing of a claim against a third party for damages by reason of an injury which comes under conditions of liability does not affect the right of the injured employee or the employee's dependents to recover worker's compensation.

An employer or insurer may share in the proceeds collected in third party suits.

[s. 102.29]

CAN AN EMPLOYER PURCHASE OTHER LIABILITY INSURANCE IN ADDITION TO WORKER'S COMPENSATION COVERAGE?

Wisconsin law does not affect the organization of an insurer, nor the right of an employer to insure against such liability, or against the liability for compensation provided by worker's compensation, or to arrange with employees, or otherwise, for the payment of sickness, accident, or death benefits in addition to the compensation provided by worker's compensation.

[s. 102.30]

WHAT NOTICE OF INJURY IS REQUIRED UNDER WORKER'S COMPENSATION?

A claim for compensation cannot be maintained unless, within 30 days after the occurrence of the injury or within 30 days after the employee knew or ought to have known the nature of his or her disability and its relation to the person's employment, actual notice was received by the employer or the employer's officers, managers, or designated representatives. If no payment of compensation is made and no application is filed with the Department of Workforce Development within two years from the date of injury or death, or when the employee knew or should have known the nature of the disability and its relationship to their employment, the right to compensation is barred. The right to compensation is not barred, however, if the employer knew or should have known about the injury or death within the two-year period.

[s. 102.12]

CHAPTER VII

RISK-SHARING PLANS

The Commissioner may, by rule, establish mandatory risk-sharing plans for automobile, worker's compensation, property, and health care liability insurance, if a demonstrated need for such plans exists. Such plans may also be set up voluntarily to meet a market need. Five risk-sharing plans have been established in Wisconsin.

[s. 619.01]

WHAT IS THE WISCONSIN AUTOMOBILE INSURANCE PLAN?

The Wisconsin Automobile Insurance Plan (WAIP) is a "risk-sharing" plan which provides coverage for Wisconsin automobile owners who are unable to obtain automobile liability and physical damage coverages due to unfavorable driving records or other underwriting conditions.

The basic purpose of WAIP is:

- To make automobile liability insurance and other automobile insurance coverages available to those who cannot obtain it through normal sources in Wisconsin; and
- To establish a procedure for the equitable distribution of risks assigned to insurance companies.

WAIP is available to residents and nonresidents who have automobiles registered in Wisconsin.

WHAT COVERAGES ARE AVAILABLE THROUGH WAIP?

Automobile liability (including private passenger) coverage minimum limits for bodily injury are \$25,000 per person and \$50,000 per accident, and \$10,000 for property damage. On request, coverage may be issued up to \$100,000 per person and \$300,000 per accident, and up to \$100,000 for property damage. Uninsured motorist coverage is limited to \$25,000 per person and \$50,000 per accident and is mandatory under WAIP. Medical payments coverage is available in amounts from \$1,000 to \$5,000.

Comprehensive and collision coverages are available on private passenger automobiles only, with deductibles of \$100, \$250 or \$500.

MAY INSURERS ASSESS A SURCHARGE UNDER WAIP?

If the hazard of a risk is greater than that contemplated by the rate normally available under WAIP, the insurer may ask the Commissioner for a rate increase for that particular risk. Any rate increase approved by the Commissioner includes any applicable additional charges.

WHAT IS THE RESPONSIBILITY OF AN AGENT UNDER WAIP?

The agent must determine that the applicant, within 60 days prior to the date of application, made an effort to obtain automobile insurance in Wisconsin and that the applicant was unable to obtain such insurance.

The agent must make sure that the applicant has properly completed the WAIP application and that the appropriate deposit premium is submitted with the application. The agent is deemed to be the agent of the applicant and not an agent of WAIP and/or the insurance company assigned to service the applicant.

It is the duty of the agent to determine if the particular risk is eligible for coverage under WAIP. The intermediary should also obtain the applicant's driving record for the past three years from the Wisconsin Department of Transportation, Division of Motor Vehicles.

The agent must send to WAIP two copies of the application and the applicant's driving record along with the required fee. A deposit fee should be paid by check payable to the Wisconsin Automobile Insurance Plan. The check and the above information should be sent to:

Wisconsin Automobile Insurance Plan
20700 Swenson Drive
Waukesha, WI 53186
Phone: (262) 796-4599

WHAT IS THE WISCONSIN WORKER'S COMPENSATION INSURANCE POOL?

The Wisconsin Worker's Compensation Insurance Pool (Pool) is a "risk-sharing" plan under Wisconsin law, and was created to provide worker's compensation insurance to any employer who is unable to obtain such insurance in the private market due to unfavorable loss history or other underwriting conditions. The rates charged in the Pool are the same uniform rates charged by all insurers in the private market.

WHO ADMINISTERS THE POOL?

The Wisconsin Compensation Rating Bureau (Bureau) acts as administrator and trustee of the Pool. The Bureau is a licensed rate service organization for worker's compensation insurance in Wisconsin. It was created by Wisconsin law and is regulated by the Office of the Commissioner of Insurance.

WHAT IS THE RESPONSIBILITY OF AN AGENT UNDER THE POOL?

It is the duty of the agent to assist the employer in meeting his/her obligations under the Wisconsin worker's compensation law. If worker's compensation insurance coverage cannot be obtained in the private market, coverage can be obtained through the Pool.

The agent should make sure that the application has been properly completed and that all supplementary information required by the Pool is attached, including but not limited to payroll verification and the appropriate deposit premium.

The agent is deemed to be the agent of the applicant and not an agent of the Pool and/or the insurance company assigned to service the risk. The agent should read and be familiar with the rules of the Pool as outlined in the Pool handbook available free of charge from the Bureau.

An agency wishing to place coverage through the Pool should write or call the Pool at the following address and phone number:

Wisconsin Compensation Rating Bureau
Box 3080
Milwaukee, WI 53201
Phone: (262) 796-4540

WHAT IS THE WISCONSIN INSURANCE PLAN?

The Wisconsin Insurance Plan (WIP) is a nonprofit unincorporated plan to provide basic property insurance, risk sharing, and assistance to Wisconsin residents in securing such insurance. All property insurance companies in Wisconsin participate in WIP and the plan is supervised by the Office of the Commissioner of Insurance.

WIP assists qualified property owners in obtaining actual cash value homeowners coverage, fire, extended coverage, vandalism and malicious mischief, and burglary and crime insurance if they have difficulty in securing sufficient insurance protection in the voluntary market. Manufacturers, farm properties, and automobiles are not eligible.

Application forms are available from all insurance intermediaries, and brokers, or directly from WIP. Each Wisconsin insurer must require its licensed insurance intermediaries to cooperate fully in accomplishing the intent and purpose of WIP.

A free inspection service determines if the applicant's property meets the minimum insurance requirements and is physically sound. If the applicant's property is deemed to be insurable, a one-year policy is issued after payment of premium.

The maximum limits of coverage for basic property insurance on fire, extended coverage, and builder's risk endorsements for loss or damage are \$200,000 on the dwelling, \$100,000 on personal property for any habitation risk at one location and \$500,000 on any other eligible property at one location.

The maximum limits of coverage for basic property coverage against loss of damage due to burglary and/or theft are \$5,000 on any habitation risk at one location and \$15,000 on any other eligible property at one location.

The maximum limits for the Plan's modified homeowner's coverage are \$200,000 on the dwelling, with the customary percentage limits for other structures, personal property, and

loss of use. The maximum limit for personal liability is \$100,000 and \$1,000 medical payments to other for any risk at one location.

[ch. 619, s. Ins 4.10]

The address of WIP is:

Wisconsin Insurance Plan
700 West Michigan Street, Suite 320
Milwaukee, WI 53233
Phone: (414) 291-5353
www.wisinsplan.com

WHAT IS THE WISCONSIN HEALTH CARE LIABILITY INSURANCE PLAN (WHCLIP)?

Wisconsin law has authorized the Commissioner of insurance to devise a plan to provide health care liability insurance to risks in Wisconsin who are unable to obtain such coverage.

The Commissioner has established a health care liability plan to provide coverage for medical professionals licensed under Wisconsin law. Those eligible include doctors, nurses, anesthetists, hospitals, podiatrists, and various public medical entities. Members of WHCLIP include all insurers authorized in Wisconsin to insure against liability resulting from personal injuries, except that town mutuals are not included. In case WHCLIP loses money, the members are assessed.

Wisconsin Health Care Liability Insurance Plan
P. O. Box 150
Wausau, WI 54401
Phone: (715) 842-6777

[ch. 619, s. Ins 3.35]

WHAT IS THE HEALTH INSURANCE RISK-SHARING PLAN (HIRSP)?

The legislature has enacted a law creating a mandatory health insurance risk-sharing plan for the residents of Wisconsin. HIRSP will provide health insurance to those eligible individuals who, for medical reasons, are unable to find adequate health insurance coverage in the private market. Insurers are required to notify consumers of the existence of HIRSP, the eligibility requirements, and the way to apply whenever they send any of the following:

- A notice of rejection or cancellation of health insurance, as defined in the statute.
- A notice of reduction or limitation of health insurance which substantially reduces benefits compared to benefits available to standard risks.
- A notice of an increase in premium exceeding 50% unless the increase applies to substantially all of the insurers' health insurance policies then in effect.
- A notice of premium for a health insurance policy not yet in effect which exceeds by 50% or more the premium charged a standard risk.

Anyone who receives one of the notices described above is eligible to apply to HIRSP.

Any person who has tested positive for the presence of HIV or an antibody in HIV is automatically eligible for coverage.

[ch. HFS 119, s. 13.93 (2m)(b)1]

The address of HIRSP is:

State of Wisconsin HIRSP
EDS
6406 Bridge Road #18
Madison, WI 53784-0018
Phone: 1-800-828-4777